

**FEMALE GENITAL MUTILATION (FGM)
or
FEMALE GENITAL CUTTING (FGC) IN BENIN**

PRACTICE:

The form of female genital mutilation (FGM) or female genital cutting (FGC) practiced in Benin is Type II (commonly referred to as excision).

INCIDENCE:

The Benin chapter of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) conducted a survey in 1992. It estimated that the percentage of women who have undergone this procedure is close to 30 percent. The World Health Organization (WHO) estimates that the percentage is closer to 50 percent. However, this figure appears high to many locally based physicians and non-governmental organizations (NGOs).

The 1992 survey found that while Type II or excision is widely practiced, the practice is not uniformly distributed throughout the country. It occurs in the northern part of the country, particularly in the departments of Atacora, Borgou, Zou and Alibori. It also occurs in some communities in the southern coastal department of Oueme. The ethnic groups most affected are the Bariba, Peul, Boko, Baatonau, Wama and Nago. The Wama and the Peul (Fulani) ethnic groups perpetrate the practice in Atacora.

ATTITUDES AND BELIEFS:

Certain ethnic groups ascribe to the belief that this practice is good for the health of girls and women and for older girls, is a part of the socialization process marking the transition to adulthood. Some older citizens defend the practice and stress the advantages of having a woman "cut" to ensure her faithfulness to her husband. Some claim that Islam or indigenous religions demand or recommend it.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

It is generally performed without the use of anesthesia. The age and ceremonial context in which the procedure takes place vary with the location. It is usually performed when a girl is between six and eight years of age among the Boko, the Baatonou and the Peul. Among the other ethnic groups that engage in this practice, it is generally performed later, between 10 and 15 years of age.

The cost of the ceremony related to this practice can run as high as 500,000 CFA (approximately US\$1000). Some families go into debt in order to bear the costs of this ceremony. Among other groups, the traditional birth attendant (TBA) or a member of the family performs the procedure. Often this person receives some payment in kind.

OUTREACH ACTIVITIES:

The government's position is to eliminate this practice in Benin. It has undertaken some activities through health workers in rural areas to inform the public about the harmful effects of the practice, but the coverage is still very light.

In April 2000, the Social Affairs Minister attended a ceremony in which 17 women turned in their cutting tools in exchange for small grants (approximately US\$175). At that time several traditional authorities, i.e. chiefs and kings, denounced the practice in a joint statement as “a backward, harmful and cruel practice.”

The African regional office of WHO launched a regional plan of action against all forms of FGM/FGC on March 17, 1997 during a symposium in Cotonou. The plan comprises three phases to be completed over a 20-year period. It focuses on coordination and reinforcement of inter-organization and inter-government involvement in West Africa. WHO/Benin's part of the plan calls for a national evaluation of the prevalence of FGM/FGC; national legislation to eliminate the practice and collaboration of government, NGOs and private sectors to establish or reinforce community-based prevention activities such as: community surveillance, information, evaluation and notification programs.

The IAC is the leading NGO in the fight against this practice in Benin. It's founder, Mrs. Isabelle Tevoedjre, a Beninese citizen and wife of the Minister of Planning, has worked for over 20 years in the campaign against FGM/FGC throughout Africa. She began her work when she lived in Geneva. She founded the local chapter of IAC in Benin in 1982. In 1983, at the Constitutive National Congress of the Organization of Revolutionary Women of Benin, the President of Benin spoke out against traditional practices harmful to women. One such practice he emphasized was that of FGM/FGC.

Workshops and seminars have been conducted by IAC/Benin. Participants have included religious and community leaders, mayors, doctors, midwives, social workers and representatives of youth and women's organizations. A pilot project was started in Atacora to inform the population about the dangers of this practice. It is being carried out in villages in the north of Benin by women specially trained for the project. They visit villages on motorcycles and inform the populace of the harmful health effects of the practice. Models and slides are used to show the actual procedure and its consequences.

In 1993, seminars were held in Natitingou, Kouande, Bante and the Parakou region. Men (religious and village leaders) participated on one day. Women (TBAs and midwives) participated on another day. Finally, a day was set aside for youth leaders, teachers and young people.

In June and July 1995, seminars were held in Natitingou, Toukountouna and Tanguieta in Atacora province. Each day 40-45 select individuals from surrounding towns and villages participated in discussions and watched a videocassette entitled “La Duperie” (The Big Lie) that featured an FGM/FGC ceremony performed on a small girl of one or two years of age. The recommendations made by participants in these seminars included calls for increased schooling, more copies of the videocassette and informational sessions on the village level. IAC/Benin also suggested that religious leaders discuss the practice with their congregations and that discussions be held on various forms of legal action against those who continue the practice.

In September 1997, IAC/Benin held information and discussion sessions in the departments of Borgou and Atacora. These were attended by women, men, youth, religious and ethnic leaders and government representatives. According to the president of IAC/Benin, awareness campaigns have been successful in urban centers. Excisors have been forced to go into rural areas where the practice still frequently occurs. Therefore, IAC/Benin plans to focus its efforts on the more isolated rural areas in the north. Its ultimate goal is to have the practice disappear by the year 2015. Over the next six years it will concentrate its activities in the Borgou department.

IAC/Benin also collaborates with the Ministry of Social Affairs and Health. The government of Benin allows the distribution of posters and informational materials in government-run clinics. In the past year two other local NGOs, “Le Levier du Developpement” and “Dignite Feminine”, have become involved in campaigns against this practice in the department of Zou and in other northern regions.

The campaign in Benin treats the problem as a community issue that concerns both men and women rather than as a woman's issue. Focus is concentrated on medical, economic and social aspects of the practice rather than making it an issue about male domination or the repression of female sexuality.

Local populations have made appeals to government representatives who travel to their areas to help them address the problem with funds and assistance. IAC/Benin interprets this as a definite change in mentality and sentiment toward FGM/FGC.

A German NGO Intact pays excisors to abandon their profession. Another local NGO "Dignite Feminine" has also been actively involved in the battle to eliminate this practice. In January 2000, it collected 60 knives from practitioners in northern Benin who voluntarily professed they were renouncing the practice. "Dignite Feminine" is following up on these renunciation ceremonies. It has reported that the situation has improved in the Save Region in the department of Collines.

In March 2000, on International Women's Day, the local chapter of the NGO Women in Law and Development-Africa launched the initiative, in collaboration with the United Nations Population Fund (UNFPA), of a convention for the elimination of all forms of discrimination towards women. During the event, a well-known female theater company performed a play that denounced practitioners of FGM/FGC and warned against the risks attendant with this practice.

WHO plans to tour villages in which excisors have decided to give up their tools. It is currently discussing with the government of Benin, how to include such activities in a concerted national action plan.

LEGAL STATUS:

No law explicitly criminalizes this practice in Benin. A decree outlawing facial scarification from 1967 falls short of guaranteeing the integrity of the body. IAC/Benin hopes that the Family Court will make a decision in the near future that will safeguard one's person explicitly in cases of FGM/FGC. To date, however, this has not happened. Some proponents against this practice are encouraging people to seek legal action against those who continue the practice.

Members of the National Network for the Elimination of Genital Mutilations (Reseau National de Lutte Contre les Mutilations Genitales) that groups together several local NGOs, are working with the Ministry of Women Affairs and Social Welfare on a proposal to outlaw this practice.

At the international symposium held in March 1997 in Cotonou to eliminate legal and cultural barriers to reproductive health in Francophone Africa, the Beninese delegation helped develop an action plan that covered several draft laws, including one against FGM/FGC. The National Assembly, however, has not yet passed a law addressing this practice.

PROTECTION:

IAC/Benin has developed a network of groups that oppose this practice that perhaps could lend assistance to a woman opposed to it. The president of the Cotonou-based Association of Women Jurists of Benin, however, indicated that her organization did not consider the practice a large enough threat (since it occurs mostly in the north) for that organization to become involved. There is no information on effectiveness of seeking local police protection.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN BURKINA FASO

PRACTICE:

The form of female genital mutilation (FGM) or female genital cutting (FGC) practiced in Burkina Faso is Type II (commonly referred to as excision). It is deeply rooted in culture and cuts across class, religion and ethnic groups. It is performed throughout the country, in all but a few of the provinces.

INCIDENCE:

According to a 1999 Demographic and Health Survey of 6,445 women nationally, 71.6 percent of the women of Burkina Faso, regardless of class and religion, and often regardless of region or ethnic group, have undergone this procedure.

It is common among all of the nation's 45 provinces, but is particularly widespread in 14 of them. Among more than 50 distinct ethnic groups, only a few such as the Bella do not practice it. Also not practicing it are members of particular castes and secret societies (such as some of the Mossi mask societies in the Koundougou province). Type II or excision is performed on women in the provinces of Mouhoun, Yatenga, Zoundweogo, Naouri, Tapoa, Ganzourgoou, Houet, Kenedougou, Comoe and Kadiogo that includes the capital of Ouagadougou. In Ouagadougou some families, however, are beginning to abandon the practice.

In some cases, even if a particular ethnic group does not practice FGM/FGC in one province, members from the same ethnic group in a different province may. For example, the Gourounsi ethnic group in Boulkiemde province does not practice it while the group in Houet province does.

ATTITUDES AND BELIEFS:

According to sociocultural beliefs, originally this practice had a single goal of assuring the fidelity of women. It is often connected with a rite of passage to adulthood and linked to cultural and/or religious beliefs. For example, young girls from the majority Mossi were traditionally secluded during the cutting and taught about their future duties as young women and mothers. The end of the girls' seclusion was marked by a village-wide celebration with drinking and dancing.

The rationale for the practice includes aesthetic and sanitary factors. Some people believe an infant will die if it touches the clitoris of its unexcised mother during childbirth. Some believe it enhances a woman's childbearing capacity. Some of the more urban women in Burkina Faso, however, believe that this practice is a way to continue the domination of women; that it is to make sure a woman is more docile and less likely to run after other men.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips). The age at which a person undergoes this practice depends on a woman's region and ethnic group.

Members of the Mossi excise their daughters at around age seven. Other ethnic groups wait until a woman is to be married or about to have her first child. Some submit their babies to this practice at birth.

Typically older women perform the procedure, earning about US\$2-3 per patient. It is generally performed without the use of anesthesia. Excisors in urban areas are often paid in cash, while those in rural areas are paid with grain or other agricultural goods. If the procedure goes without complications, the excisor can also expect gifts such as chickens or guinea fowl, soap and expensive fabric. If complications follow, they are often attributed to failed pre-operation sacrifices made to the ancestors rather than a failure on the part of the excisor.

Complications can include, for example, keloids, hemorrhaging, anemia, damage to tissue around the vagina and rectum, incontinence and even death.

OUTREACH ACTIVITIES:

A radio campaign first raised the issue of FGM/FGC in 1975, demanding that the practice cease. In 1985, a recommendation was made during "National Week for Women" to abolish it. The people of Burkina Faso began to discuss this formerly taboo subject. Since then there have been numerous campaigns, seminars, etc. aimed at informing the populace about the harmful effects and eradicating the practice. Much emphasis has been placed on the improvement of health care and education, participation of women in society and economic and social improvement of the position of women and children.

The government of Burkina Faso continues to wage a serious campaign against this widespread practice. The campaign, based on informing the people of Burkina Faso about health problems posed by excising a woman, is led by a National Committee to Fight Against the Practice of Excision (CNLPE) with Burkina's First Lady as the honorary chairperson. The First Lady actively supports the campaign.

The National Committee was set up by a Presidential decree in 1990. Included in the Committee are members of the Burkina Faso Women's Union, the Burkina Faso Midwives' Association, the Nurses' Association and the Burkina Faso Movement for Human and People's Rights. Traditional village leaders have pledged their support to the Committee.

Members of the National Committee state that people are beginning to resist this practice but that traditional beliefs are so powerful that many girls and women are either obliged to or want to undergo the procedure. In one case, for example, a six-year old girl came to her mother asking to have the procedure so she would be like her friends. Her mother refused her request.

The National Committee operates under the administration of the Ministry for Social Action and the Family, but maintains autonomy in its activities. It is composed of three main bodies: a National Committee, a Permanent Secretariat and a Provincial Committee and one subsidiary group of resource people.

The National Committee oversees all actions against FGM/FGC at a countrywide level. It mobilizes resources and different sectors, promotes research, collects and publishes relevant data about this practice and monitors and evaluates activities. It has lobbied and succeeded in getting the government to identify it as a public health priority, include a "symbolic" budget line in some of the provincial administrative budgets for its eradication, facilitate fund raising by holding round-table gatherings with potential donors and adopt the National Committee's reports and documents as official government texts.

The core of the National Committee's work has been conducting five-day training sessions for National Committee and Provincial Committee members and three-day awareness campaigns among the general population. These sessions are very detailed and include films and videos on the practice, history and consequences. Specific training sessions have been developed and targeted to a variety of different professions: traditional leaders, Islamic associations, churches and pastors, women's associations, health professionals, birth attendants, police, teachers, youth and press/media. Posters, pamphlets, brochures and stickers are handed out. One colorful sticker depicts a young girl shielding her pubic area with widespread hands. A feature-length movie made by a Burkina cinematographer called "My Daughter Will Not Undergo Excision" is shown. It ends with the death of a young girl following the operation.

After this training, each of these groups is asked to develop strategies to fight the practice. Traditional leaders have organized seminars and awareness sessions at the canton, village and family levels. Islamic association members have created a national committee to organize awareness

campaigns. Religious leaders are encouraged to speak against the practice during services and special ceremonies. Youth now develop skits, plays and radio contests to spread information about the practice to other young people. Police have established files on known excisors, including their whereabouts. The National Committee, with the help of police, has identified excisors and given them training. Police have organized community patrols and regularly talk with families in the street about the harmful effects of the practice and that it is prohibited under the law.

Finally, the National Committee has established a 24-hour SOS telephone hot line about the practice. People can use it to report cases. If the excision has not yet occurred, Committee members visit the families. If it has already occurred, the parents are served notice to report to the police, as is the excisor.

In July 1992, the National Committee launched a campaign aimed at seven communities in Ouagadougou and in the villages of Kadiogo province. Information was provided on the dangers of this practice and discussions ensued.

The National Committee has been working on the development and production of education material with the National Literacy Institute. The President of the National Committee against Excision has gone on prime-time national television to talk about the practice. So far the Committee members have put their efforts into teaching the public about the harmful health effects. Outreach workers also tell higher educated audiences that a woman who has undergone this procedure is less likely to respond to sexual stimulation.

Activities to inform the populace about this practice continued in 1997. A workshop was held on strategies to fight against this practice by Islamic organizations. Several mosques in Ouagadougou were used for this campaign. A second campaign focused on Catholic leaders in Ouagadougou parishes. Information sessions about the harmful effects of the practice were held for 25 gendarmes in Ouagadougou. The purpose was to train them to disseminate this information among their colleagues and to collect information on excisors so they could watch them for possible FGM/FGC activities. A similar workshop was held with judicial and administrative officers and lawyers to inform them about the harmful consequences of the practice and ways to enforce the law against the practice.

Excisors now are more likely to use sterile equipment. Some of the effects of the campaign, however, are not what opponents of the practice had hoped for. Parents now are more likely to have their daughters excised at birth when the operation is less likely to be noticed. Rural puberty ceremonies are more likely to be hidden and more focused on the procedure, with less attention on traditional rites and celebration.

One of the factors slowing down the progress on the anti-FGM/FGC activities has been lack of financial support. Also, Committee members are volunteers and must carry out this work in their free time. The local office of the U.S. based Population Council has done research showing the men have tremendous influence and could stop this practice.

In June 1998, the Heads of State and Government at the meeting of the Organization of African Unity (OAU) in Burkina Faso endorsed the 1997 Addis Ababa Declaration on Violence Against Women which includes a call for the eradication of the practice of female genital mutilation.

The U.S. Embassy's Democracy and Human Rights Fund in Fiscal Year 2000 supported a Burkina filmmaker to produce a documentary film on the causes and consequences of FGM/FGC.

LEGAL STATUS:

A law prohibiting FGM/FGC was enacted in 1996 and went into effect February 1997. A Presidential decree had earlier set up the National Committee against this practice and imposed fines on people guilty of excising girls and women. The law includes stricter punishment for those involved in the excision of women and girls. The law reads as follows:

-Article 380: A prison sentence of six months to three years and/or a 150,000 to 900,000 francs (US\$240-1,440) fine to whomever attempts or succeeds at damaging the physical integrity of a woman's genitalia by total ablation, excision, infibulation, desensitization or all other methods. If death follows, the prison sentence is five to ten years. Similar sentences are applicable to those who request, incite to excision or promote it either by providing money, goods, moral support or all other means.

-Article 381: Penalties will be applied to the fullest extent of the law if the guilty party belongs to the medical or para-medical corps. The judge can additionally forbid the guilty party to practice his or her profession for a maximum of five years.

-Article 382: Imposition of a fine of 50,000 to 100,000 francs (US\$80-160) on all persons who knew the criminal behavior described in Article 380 was to take place and did not warn the proper authorities.

Since the adoption of this law, there have been 60 convictions of both excisors and accomplices, resulting in sentences of imprisonment or fines. Imprisonment for excisors has ranged from one to ten months. One excisor received a ten-month jail sentence for cutting two girls. Accomplices have also received prison terms. Both have received fines of from 10,000 to 50,000 francs (approximately US\$16-80). In a number of cases, prison sentences were suspended.

PROTECTION:

The National Committee Against Excision believes that using law enforcement authorities is a crucial element for an effective campaign against this practice in Burkina Faso, because the tradition and rites attached to it are so pervasive. The practice has survived other campaigns. Missionaries began the fight against it early in the century and officials of Burkina Faso began work on the issue in the 1970s. There is still a strong demand for it.

The Ministry for Social Action and the Family, when notified of an excision taking place, has taken the people responsible to the police. The National Committee Against Excision is also becoming increasingly interested in seeing that legal action is taken against those involved. Empowered by the 1990 Presidential decree, Committee members asked police to detain excisors found to have performed this procedure for 72 hours and to impose fines of about US\$5 per patient. The revisions to the Penal Code, however, have made these punishments much stronger. One of the results of the law has been to detain both parents who have had their daughter(s) excised.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN CHAD

PRACTICE:

The most common form of female genital mutilation (FGM) or female genital cutting (FGC) widely practiced in all parts of Chad is Type II (commonly known as excision). Type III (commonly known as infibulation) is confined to the eastern part of the country in areas bordering Sudan. The practice crosses

ethnic and religious lines. It is practiced by Christians, Muslims and Animists in roughly equal proportions.

INCIDENCE:

A 1995 United Nations report on FGM/FGC in Africa estimated that 60 percent of the women in Chad have undergone one of these procedures. Its frequency is higher in rural areas.

A 1991 survey conducted by UNICEF in three regions showed that in the south (Moyen Chari and Logone Oriental), 68 percent of the women there favored this practice, while 37 percent of the men believed it to be desirable. In the central and eastern regions (Guera and Ouaddai), 85 percent of the women questioned supported the practice as did about an equal percentage of the men. In N'Djamena, however, only 37 percent of the women and 25 percent of the men favored it.

ATTITUDES AND BELIEFS:

These procedures are usually performed on girls as part of their rite of passage into womanhood. It is deeply rooted in tradition.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are generally bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

These procedures are generally performed without the use of anesthesia.

OUTREACH ACTIVITIES:

The government of Chad has been a facilitator that provides an enabling environment for the non-governmental organization (NGO) community to undertake long-term programs deemed necessary to change people's attitudes about this practice. The Ministry of Social Action and the Family coordinates activities dealing with this practice. In its Fiscal Year 2001 budget, the government included a line item to support the activities of ASTBEF (Chadian Association for Family Well-Being), which is the leading NGO active in combating this practice.

The local NGO community has provided the impetus for an ongoing FGM/FGC eradication campaign. Several NGOs have organized conferences, debates and education programs on the issue. ASTBEF has emerged as the leader in this effort.

The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) is active in outreach programs. The World Health Organization (WHO) is also active in mobilizing government and private efforts to halt this practice.

The U.S. government, through the U.S. Embassy's Democracy and Human Rights Fund (DHRF) supported a locally initiated multi-faceted education program to eliminate this practice during 1997-1999. This included public announcements using the broadcast and print media; production of a theatrical presentation showing the harmful consequences of the practice; a round table discussion with 40 doctors, judges, parliamentarians and NGO representatives; a national seminar for 30 regional administrators and

Parliamentarians on this issue; and four regional seminars for 150 opinion leaders and FGM/FGC practitioners.

ASTBEF plans to use its Fiscal Year 2000 DHRF grant to implement education programs in 46 Cantons in six regions where the practice is believed to be the highest. The message will include the negative health effects, as well the criminal nature of the procedure when the new proposed law becomes effective.

ASTBEF was invited to the October 7, 1999 Council of Ministers meeting to explain the negative effects of this practice to the President, Prime Minister and Cabinet.

The media plays a major role in informing the public about this issue. As a result, public awareness is growing. A film produced by Zara Mahamat Yacoub in July 1997, documented this operation and had a profound effect on the population who viewed this production on prime-time television. Though the broadcast raised an outcry from religious leaders, it brought the subject into the public and made it a subject of debate. Local human rights associations have also organized conferences and debates on this subject.

LEGAL STATUS:

Although there is no law specifically making these practices a crime, jurists claim that under the existing Penal Code, the practices are prosecutable as an involuntary physical assault against a minor. A new law, still in draft stage, has been adopted by the Council of Ministers and is expected to go before Parliament in 2001. It would specifically criminalize this practice. ASTBEF provided technical input to the parliamentary committee drafting the law.

PROTECTION:

In N'Djamena, limited mechanisms exist to provide counseling and legal protection for women. The Chadian Association of Women Jurists has since 1999, provided this type of service. However, as a rule adult women in Chad do not undergo this practice. It is practiced as an initiation rite of passage for girls into womanhood. These minors are for the most part, unwilling to defy parental authority and seek protection or counsel from the associations that might provide it.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN COTE D'IVOIRE

PRACTICE:

The form of female genital mutilation (FGM) or female genital cutting (FGC) practiced in Cote d'Ivoire is Type II (commonly referred to as excision). The practice is prevalent among Muslim women and is also deeply rooted in traditional Animist initiation rites in western, central and northern Cote d'Ivoire. It crosses ethnic and socioeconomic lines. Some believe the practice seldom occurred among the original population but was imported by immigrants from neighboring countries.

INCIDENCE:

According to a 1999 Demographic and Health Survey of 3,040 women nationally, 44.5 percent of the women of Cote d'Ivoire have undergone Type II.

Informing the public about the harmful effects of this practice, imposing legal sanctions on those that perform it or let their children be excised and other factors, however, are slowly attenuating the practice. It is found particularly among the rural populations in the north, center and west of Cote d'Ivoire.

Generally speaking, this practice occurs among two often overlapping groups: Muslim women and women undergoing Animist initiation rites. Muslim groups include the northern Mande (Malinke, Foula, Bambara, Dioula) and some members of the Voltaic groups (Senufo, Tagwana, Djimini, Lobi, Birifor, Koulango) of the north. The southern Mande of the west (Dan, Yacouba, Toura, Gouro), many of whom are not Muslim, the We from the Krou group and Baoule in some villages surrounding the central city of Bouake also practice FGM/FGC. Some Muslim leaders condemn it as not taught by the Quran.

ATTITUDES AND BELIEFS:

This practice is now deeply rooted in regional traditions. Initiation rites featuring this procedure are common in many villages. The tradition is part of a young girl's dream of womanhood and social integration, her mother's desire to host an elaborate party and celebration and the family's way of supporting social convention.

The practice on village women is strongly linked to the survival of local secret societies and mask-cults at the heart of village spiritual life. The clitoris is thought to possess power and its removal during initiation gives that power to the village spirits and traditional spiritual leaders or masks, without which the spirits/masks and the entire village would die. Attempts to eradicate the practice, or even to transform it from a physical to a symbolic act, are perceived as threatening to "assassinate the people" of the village.

Reporting on a seminar it held on tradition, the Ivoirian Association for the Defense of Women's Rights (AIDF), the most active Ivoirian non-governmental organization (NGO) in the fight against violence against women and FGM/FGC, said: "Tradition is the foundation of society. Questions of tradition remain taboo because the desire to explain the irrational would lead to the incrimination of certain traditions and, consequently, of an entire social system in which woman and child occupy a place of little worth."

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

Persons who perform this procedure are usually older women who thus make their living. The procedure is generally done without the aid of anesthesia and outside modern medical facilities. The excisor uses a knife or razor blade. She often brings along accouterments of her calling - a long strand of metal bells and sacks filled with bottle caps. These are used by other women present during the ceremony who shake the noisemakers covering the cries of pain. The excisor often sings traditional songs. It is not unknown for the excisor to cut several girls at a single ceremony presenting obvious health risks.

FGM/FGC carried out in childhood in the village usually takes place between four and seven years of age. If the girl goes away to school, the procedure may be performed later when she returns home for vacation. Such girls have been known to ask for it between the ages of 15 and 20. Occasionally, it is performed on babies.

Figures on the number of woman who undergo this procedure later in life or under duress are unknown. Pressure is most common in cases where an unexcised woman is preparing to marry a man whose family demands that she be excised, as a girl who has not been excised is regarded as dirty. In

such cases, it is generally the mother-in-law or grandmother-in-law who pressures the woman into undergoing it. However, the husband may also demand it as an excised woman is thought to like sex less and be more faithful to her husband. If a woman refuses to submit to the wishes of her in-laws, she challenges the power structure of the entire extended family. This can become grounds for interrupting or canceling a marriage.

Due to the 1998 legislation and publicity, residents of Cote d'Ivoire are gradually beginning to recognize the dangers of the practice. These include bleeding immediately following the procedure; infection following the procedure or later in life; increased vulnerability to sexually transmitted diseases and the re-opening of the scars with every childbirth. In August 1998, a young girl died in Seguela from complications after undergoing this procedure. In May 2000, a young Burkinabe girl died from blood loss after undergoing the procedure in Abidjan's Abobo district.

OUTREACH ACTIVITIES:

AIDF works with local women's committees, religious leaders and the government to raise awareness of the health issues related to the practice. It holds seminars that include both women who perform the procedure and anti-FGM/FGC activists, as well as seminars to educate national and local political and administrative authorities, traditional chiefs and police officers and gendarmes on the negative consequences of this practice.

A June 1996 AIDF seminar, which was financed by the U.S. Embassy, exposed the importance of this practice as a moneymaking activity for village excisors and a source of prestige for village excisors. At the end of the seminar, the participants adopted the idea of creating a National Committee to fight this practice. On September 30, 1996, the Ministry of Women's Affairs and Family officially inaugurated this Committee and named the Minister of Women's Affairs and Family as its chairperson. It is run by a former excisor who performed FGM/FGC for 40 years in the western region of Bangolo. She decided to abandon the practice following the various campaigns against it. The Committee includes Muslim Imams, the President of the Association for the Well-Being of Women and some women leaders.

In June and July 1997, with the financial assistance of the U.S. Embassy, AIDF visited several towns and villages in western and northern Cote d'Ivoire to inform the populations about the impact of negative traditions, including FGM/FGC, on women's rights. November 25-27, 1997, also with the financial assistance of the U.S. Embassy, AIDF held another seminar in Bouake. The seminar targeted numerous civil servants, police officers and magistrates. It focused on the harmful consequences of the practice on women's health and the importance of their role in the fight against it.

The government and various national and international organizations such as the International Association for Development in Africa (AID-Afrique), the Association for the Promotion of the We culture, United Nations Children's Fund (UNICEF), Amnesty International and the Federation of the Red Cross also held several seminars in 1996, 1997 and 1998. On March 29, 1996, Amnesty International held a conference on the practice as a violation of women's rights.

From September 28 to October 1, 1998, the Red Cross held an international seminar in Abidjan to examine the consequences of the practice and to elaborate a plan to eradicate it. From May 28 to 30, 1998, the regional Department of Culture, Amnesty International and UNICEF organized seminars on the practice and its consequences in Guiglo and Tai in western Cote d'Ivoire. These seminars included excised women, doctors, lawyers, religious leaders and a delegation from AIDF.

AIDF also led the fight against "medicalization" of the practice. The government of Cote d'Ivoire, through the Ministry of Women's Affairs and Family and the Ministry of Public Health, treats FGM/FGC as a health issue. With the outcry against the unsanitary conditions associated with it, performance of the procedure has been moving into hospitals and dispensaries. Although the move into hospitals decreases immediate chances of infection and hemorrhage, even the procedure carried out under sanitary conditions can lead to serious health problems later in life. AIDF, the government and other national and

international organizations are against medicalization of the practice, as they fear that it will only serve to legitimize it.

The Gynecological and Obstetrical Society, the National Federation of Midwives and the Association for the Well-Being of the Family have used radio and newspapers to combat this practice. They believe that these activities should be a part of safe motherhood projects. In addition, a National Committee of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) was set up in Abidjan in 1992. The IAC fights the practice through existing community structures, such as youth hostels, institutions for female education and maternity hospitals.

March 18 to 20, 1998, the Ministry of the Family and Women's Affairs organized a seminar in connection with the government's proposed bill banning FGM/FGC. The seminar included members of Parliament, various women's NGOs and institutions active in the fight against the practice. While waiting for the bill to be passed, AIDF pursued its information and education campaign and finally succeeded in getting some excisors in Bangolo to abandon the practice in September 1998. Encouraged by this first success in the west, in November 1998, AIDF focused its next action in the north, holding a series of seminars with financial assistance from the U.S. Embassy. To date, no excisor from the north has come forward to announce that she has abandoned the practice.

The process of informing Ivoirian women and society as a whole of the dangers of this practice is slow. Tradition makes it a touchy subject. As women and girls become more aware of the harmful health effects through the numerous campaigns of information and education, however, the practice is starting slowly to disappear. The fact that a greater number of Ivoirians are now living in towns, far from the elders and the traditions, is also playing an important role in the progressive eradication of this practice.

In 1998, as a result of the vigorous campaign led against FGM/FGC by the government, AIDF and a number of other NGOs and institutions, traditional and religious authorities that have generally upheld the practice, began to take part in public demonstrations against it.

LEGAL STATUS:

A December 18, 1998 law provides that harm to the integrity of the genital organ of a woman by complete or partial removal, excision, desensitization or by any other procedure will, if harmful to a woman's health, be punishable by imprisonment of one to five years and a fine of 360,000 to two million francs (approximately US\$576-3,200). The penalty is five to twenty years' incarceration if the victim dies and up to five years' prohibition of medical practice, if this procedure is carried out by a doctor.

Before the 1998 law was enacted, existing provisions of the Criminal Code could be used to prohibit this practice. However, despite laws on the books governing crimes against the person, there were no Ivoirian cases of women challenging this practice in court.

PROTECTION:

Before the adoption of the 1998 law, the possibility of enforcing a law at the village level, where the practice is most likely to take place, was almost nil. The powerful association of this practice with religion and witchcraft made reporting and prosecuting excisors virtually impossible. Furthermore, the government had no interest in imposing the existing laws on unwilling families and antagonizing village elders and chiefs who are the guardians of tradition. This has begun to change.

Following the adoption of the law in 1998, the government and the various NGOs and institutions fighting this practice gave themselves some time to pursue information and education campaigns before requesting the enforcement of the law. In 1999, AIDF launched an intensive campaign aimed at

informing the population, law enforcement authorities and local government officials of the existence of the law.

The campaign gathered momentum when AIDF's president was appointed Minister of Family and the Promotion of Women in January 2000. During 2000, her Ministry and AIDF held several seminars in the regions where the practice is most prevalent, working primarily with police officers and gendarmes, administrative authorities (Prefects and Sub-Prefects), as well as traditional, political and religious authorities.

AIDF focused on information dissemination and enforcement of the new law. The Minister received additional support from the Ministries of Interior and Security. In addition to the formal seminars, the Minister used every opportunity, such as the inauguration of economic projects, to talk to women and local authorities about the negative impact on women of harmful traditional practices. The Minister also initiated a basic management training and small economic projects implementation program for excisors willing to abandon the practice. The first beneficiaries of this program were women from Bangolo in the west and women from Kaniasso in the north.

As a result of this campaign, several excisors were arrested for performing this procedure in the north during 2000. Prior to these arrests, the arrest and prosecution of parents or of excisors only occurred following the death of the excised person. Two excisors from Guinea were arrested in Abobo on May 6, 2000

and jailed following the death of a young Burkinabe girl who had been excised. On July 12, 2000, two Ivoirian women were arrested in Kongasso and jailed in Seguella, in the north, for having excised girls aged 10-14.

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FEMALE GENITAL MUTILATION (FGM)
or
FEMALE GENITAL CUTTING (FGC) IN DJIBOUTI

PRACTICE:

The two forms of female genital mutilation (FGM) or female genital cutting (FGC) widely practiced throughout Djibouti are Type II (commonly referred to as excision) and Type III (commonly referred to as infibulation). Type III is the most common form and is practiced among the Issa and Afar. Type II is practiced on girls of Yemeni origin.

INCIDENCE:

Various estimates are that between 90 and 98 percent of young girls in Djibouti have undergone Type II or Type III. The practice is firmly entrenched among the Issa and Afar who make up the overwhelming majority of the population of Djibouti. It is practiced on 41 percent of girls under the age of five and on 95 percent of girls under the age of ten.

ATTITUDES AND BELIEFS:

The practice of FGM/FGC is deeply rooted in custom that is often defended on religious (Islamic) grounds, despite the fact there is no mention of the practice in the Quran.

Although the practice has long been entrenched in the culture and society of Djibouti, young women in the early 1980s initiated discussions and called for its abolition. Some progress and changes in attitudes have slowly been made. The official policy in Djibouti is to discourage Type III as a first step towards change.

TYPE II:

Type II is the excision (removal) of the clitoris together with all or part of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening leaving a very small opening, about the diameter of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are generally bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

Type II and Type III are generally performed without the use of anesthesia.

OUTREACH ACTIVITIES:

In 1987, a National Committee with members from the Ministries of Health, Justice and Education, as well as from the Red Crescent Society and "Union Nationale des Femmes de Djibouti" (UNFD), was set up. The Committee works under the umbrella of UNFD. UNFD advocates complete abolition of this practice.

UNFD used to run a dispensary at its headquarters where girls were brought in for a less radical form of the procedure (Type II). This was performed by a traditional excisor, but the girl was given a local anesthetic before the operation. It was believed that a less radical form could be encouraged through control in the dispensary. While protecting girls from Type III in many cases, this did not prove to be totally successful in stopping it in all cases brought to the dispensary. In some cases, grandmothers took the girls home complaining that the procedure was incomplete. They then had the girls infibulated. UNFD has now closed its dispensary.

The government has incorporated awareness about FGM/FGC into its national program to promote safe motherhood. It has a focal person at the Ministry of Health who deals specifically with women's health issues. Non-governmental organizations (NGOs) and international organizations are free to disseminate information and provide training and education about the harmful effects of the practice. The Ministry of Health allows use of clinics and health training centers for distribution of information about FGM/FGC and other harmful health practices.

The Ministry of Information encourages media coverage of information relating to conferences on this topic. Neighborhood leaders are appointed to promote public awareness campaigns. They are perceived as playing an important role in the dissemination of information.

The Association for the Equilibrium and Promotion of the Family (ADEPF), a local NGO, runs programs to inform the population about the harmful effects of this practice. The international NGOs, the Red Sea Team International and Caritas also work to end the practice in the country. Caritas is very

active, printing posters and educational material and working with the Ministry of Health, local NGOs, the United Nations Children's Fund (UNICEF) and other organizations.

The United Nations Population Fund (UNFPA) is active in Djibouti in anti-FGM/FGC campaigns, working closely with the Ministry of Health, NGOs and health workers. UNICEF is also involved in these efforts.

Both UNFD and ADEPF raise public awareness by instructing school children and women's groups on the harmful health effects of this practice. They organize national seminars, workshops and training for traditional birth attendants (TBAs), information sessions for target groups such as religious leaders, mothers, fathers and policy-makers and conduct publicity campaigns. They also participated in the production of a film about the issue in Djibouti.

In 1997, the National Committee of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in Djibouti produced a film on FGM/FGC and other harmful traditional practices, which was shown on national television. After the showing a roundtable was held with members of IAC/Djibouti, doctors, religious leaders, traditional healers and TBAs. They all agreed that the practice had harmful health consequences and was not justified under science, religion or culture.

There have been a number of declarations made about this practice, including that of the State Prosecutor who said, "...I wish to remind that the Republic of Djibouti has ratified the Convention on the Rights of the Child, thus committing itself to put an end to all harmful treatments directed to children. The suffering endured by innocent children is intolerable and reprehensible. Such criminal acts are provided for and punishable by article 324 and following of the Penal Code. From now on, instructions will be given to all police forces in order for those who carry out such harmful practices to be prosecuted and punished by law."

UNICEF and the World Health Organization (WHO) are the major international organizations involved in campaigns in Djibouti. A WHO representative also trains village birth attendants about the dangers of this practice.

There is an increased awareness, especially in the rural areas, of the harmful effects of this practice. Medical personnel throughout the country are aware of the law criminalizing this practice. Posters against the practice are found throughout the country. Anecdotally there has been a move toward using the less radical form, Type II, instead of Type III, especially in Djibouti City. This has been attributed, in part, to increased public awareness through campaigns and openness among the population in discussing the subject.

The newspaper "La Nation" has carried a few articles, interviews and short messages to make the public aware of the harmful health effects of the practice. Radio and television advertisements have also been used to raise awareness of the effects of the practice.

A major obstacle to disseminating information about this subject is the illiteracy rate. An ADEPF report states that 72 percent of Djiboutian women are illiterate. In response, UNFPA, UNFD, Caritas, Red Sea Team International and other groups use street theater, story telling and other means of communication more in line with the oral traditions of Djiboutian society to get their message across.

The U.S. government, through the U.S. Embassy's Democracy and Human Rights Fund (DHRF), has provided funding for education programs by local NGOs to end this practice. It has provided funds to ADEPF and to the Red Crescent Society. In 1996, ADEPF received US\$24,871 to conduct an FGM/FGC survey, to provide education to school children and women's groups on the health effects of the practice and to organize a television debate on the subject. In 2000, the Red Sea Team International received US\$18,010 to provide health education and human rights awareness (including violence against women and FGM/FGC) for women and children throughout Djibouti.

LEGAL STATUS:

This practice was outlawed in the country's revised Penal Code that went into effect in April 1995. Article 333 of the Penal Code provides that persons found guilty of FGM/FGC will face a five year prison term and a fine of one million Djibouti francs (US\$5,600).

Enforcement to date is quite another matter. The UNFD is aware of only one case in which a young woman had to be hospitalized after undergoing the operation where the "midwife" who performed the operation was given "counsel." She was advised not to continue her practice. Apparently, no formal charges were brought.

PROTECTION:

We are unaware of any groups or organizations that provide protection to someone who wants to avoid this practice.

A woman faces no legal or economic repercussions in Djibouti if she has not undergone FGM/FGC. There is often social pressure, however, from relatives to at least undergo Type II. Local traditions and social pressure are the main impediments to the abolition of this practice.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN EGYPT

PRACTICE:

The most common forms of female genital mutilation (FGM) or female genital cutting (FGC) still widely practiced throughout Egypt are Type I (commonly referred to as clitoridectomy) and Type II (commonly referred to as excision). These practices are widespread but are even more prevalent in rural than urban areas. They are common among both Muslims and Coptic Christians. Type III (commonly referred to as infibulation, but in Egypt is referred to as "Sudanese circumcision") is found only among a few ethnic groups in the southern part of the country.

INCIDENCE:

In 2000, the U.S. Agency for International Development (USAID) funded the fourth in a series of Demographic and Health Surveys (DHS) conducted in Egypt. This nationally representative survey of 15,648 ever-married women aged 15-49 found that the practice is nearly universal among women of reproductive age in Egypt. Preliminary analysis of the 2000 findings show that 97 percent of women surveyed have undergone one of these procedures, which represented no change from the 1995 DHS findings. The most severe form, Type III, is rare.

Data from the 2000 DHS shows some progress in terms of percentage of daughters (aged 11-19) of women surveyed who have undergone this procedure (78 percent in 2000 versus 83 percent in 1995) and in the intention of women surveyed to have their daughters undergo one of these procedures (31 percent in 2000 versus 38 percent in 1995).

The 1995 DHS survey (detailed data from the 2000 survey is not yet available) indicated that two-thirds of girls had the procedure when they were between the ages of seven and ten years. Fewer than five percent were under the age of five and fewer than three percent were over the age of 13.

ATTITUDES AND BELIEFS:

There is no doctrinal basis for this practice in either Islam or Christianity. Although high officials in both the Muslim and Christian religious establishments have voiced opposition to the practice, it is still supported by some local religious authorities. Moreover, many Egyptians believe that this is an important part of maintaining female chastity, which is part of religious tradition.

The historical roots of the practice date back thousands of years. According to the 1995 DHS findings, the most commonly given reason (58 percent) for supporting the practice was the belief that this was a "good tradition." Almost three-quarters of Egyptian women felt that husbands would prefer their wives to undergo the procedure. More than one-third cited cleanliness as a reason, while a smaller number saw it as a way to prevent promiscuity before marriage and unfaithfulness within the marriage.

The 2000 DHS also found that the majority of women think this practice should continue, though there was some decline in support for the practice (75 percent of women surveyed in 2000 versus 82 percent in 1995). There is spreading recognition of the many potential adverse health consequences of the practice, which has resulted in increasing resort to doctors rather than traditional birth attendants (TBAs) to perform the procedure.

One of the main factors behind the persistence of the practice is its social significance for females. In communities where it is practiced, a woman achieves recognition mainly through marriage and child bearing and many families refuse to accept as a marriage partner, a woman who has not undergone the procedure.

TYPE I, TYPE II AND TYPE III:

These practices are widespread throughout Egypt. A recent clinical study indicated that 19 percent of the procedures involved only the excision (removal) of the prepuce (clitoral hood) with or without removal of a part or all of the clitoris (Type I). Sixty-four percent involved the excision (removal) of the prepuce (clitoral hood) and clitoris together with part or all of the labia minora (inner vaginal lips)(Type II). In eight percent of the cases, only the labia minora were removed.

Type III, the most harmful and dangerous form, is rarely practiced except among a few groups in the southern part of the country. Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening. Only a very small opening is left, about the diameter of a matchstick, to allow for the flow of urine and menstrual blood. Only one percent of the women in the study reported that the vaginal area was sewn closed at the time they had the procedure and two percent of their daughters' procedure involved a closing of the vaginal area.

In the past, the majority of these procedures were performed by "dayas" (TBAs). However, according to the 1995 DHS survey, the use of medical practitioners (doctors or trained midwives) has tripled to 55 percent in recent years, with a concomitant drop in the use of "dayas."

The procedure is usually performed in the home, although before the 1996 ban (see legal status below) some procedures were done in private or government hospitals. It is likely that some physicians continue to carry out the procedure in their private clinics as well as in private homes. In a very few cases a male barber (three percent) or "gypsy" (seven percent) may also perform the procedure.

Among older women, the procedure generally was performed without any anesthetic. However, the same women reported that almost 75 percent of their daughters who had the procedure received

either a general or local anesthetic. When the procedure is performed by a non-physician, the local anesthetic may or may not be applied effectively.

LEGAL STATUS:

The legislative background has changed over the years. In 1959, a ministerial decree forbade the practice and made it punishable by fine and imprisonment. A series of later ministerial decrees allowed certain forms but prohibited others. Doctors were also prohibited from performing the procedure in government health facilities. Non-medical practitioners were forbidden from practicing any form.

In 1994, due to public outcry over a CNN television broadcast of the procedure performed on a nine year old girl by a barber, the then-Minister of Health decreed that the procedure should be performed one day per week in government facilities but only by trained medical personnel, if they failed to persuade the parents against it. He rescinded his decision in 1995, however, after various protests and international outcry deploring the “medicalization” of the practice.

In December 1997, the Court of Cassation (Egypt’s highest appeals court) upheld a government ban on the practice of FGM/FGC. Issued as a decree by the Health Minister in 1996, the ban prohibits all medical and non-medical practitioners from performing FGM/FGC in either public or private facilities, except for medical reasons certified by the head of a hospital's obstetric department. We are unaware of any instance where this practice was certified. Perpetrators are subject to the loss of their medical licenses and can be subjected to criminal punishments. In cases of death, perpetrators are also subject to charges of manslaughter under the Penal Code.

There have been press reports on the prosecution of at least 13 individuals under the Penal Code, including doctors, midwives and barbers, accused of performing FGM/FGC that resulted in hemorrhage, shock and death. We cannot confirm these reports.

OUTREACH:

A number of non-governmental organizations (NGOs) exist in Egypt to combat this practice. A Task Force was formed under the aegis of the National Commission for Population and Development (an NGO) following the 1994 International Conference on Population and Development (ICPD). It is taking a leading role in addressing this issue and reaching the community through various local NGOs. The Task Force meets on a quarterly basis in different parts of Egypt and invites representatives from different local and international organizations that work in this area. The group targets mothers, clinics, family planning centers, secondary school students and young men and women workers. Members of the Task Force continue to teach, raise awareness about the issue and compare notes on successful strategies.

Current efforts have focused on community-based approaches and the Positive Deviance Approach that uses individuals who have deviated from tradition and stopped, prevented or oppose the practice, to advocate for change.

Other NGO activities in 2000 included several seminars on this practice by the National Commission for Population and Development and a seminar by the Population Council for NGOs, donors and researchers with the purpose of sharing experiences in the fight against this practice.

On the governmental level, in 1999 the Ministry of Social Affairs signed a project agreement with the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA) and the World Health Organization (WHO) to combat all practices harmful to women, including eradicating this practice by 2010.

In 1979, a seminar was held in Cairo called “Bodily Mutilation of Young Females”. It brought together various representatives of the Arab League, UNICEF, WHO and ministries of the Egyptian government and passed resolutions opposing the practice. In 1982, a project was funded by the Population Crisis Committee and the Cairo Family Planning Association to carry out the 1979 resolutions.

Educational materials were produced and training was carried out on the harmful effects of the practice for doctors, nurse, midwives and social workers.

The National Committee affiliated with the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) has been active since 1985. The Cairo Family Planning Association now works as the home of the Egyptian National Committee of the IAC. It has worked intensively to stop these practices. Activities focus on information and communication seminars and workshops that are designed to reach policy makers, community leaders, future mothers, nursing mothers, various male groups, health workers and TBAs.

The government and NGOs have used the mass media to disseminate information on the health risks of this practice. Government newspapers and magazines publish stories presenting the views of prominent figures in medicine and academia that oppose this practice. The government broadcasts television programs condemning this practice. Senior government officials, including the Minister of Health and Population, have appeared on television to discuss the issue as both a health issue and a religious issue.

The senior Islamic authority in Egypt, the Sheikh of Al-Azhar and the Mufti, have stated publicly on a number of occasions that this practice is not required by Islam. They have also declared the practice to be a question of health; if a doctor recommends against it, the procedure should not be performed. The leader of the Egyptian Coptic community, Pope Shenouda, has also stated publicly that this practice is not required for religious reasons. The discussion of this practice and its harmful health effects has been added to the curriculum in the school system.

In cooperation with the Egyptian government, USAID Cairo is currently carrying out the following efforts to eradicate this practice.

--The Population IV Project supports training on the hazards of this practice as part of reproductive health training programs for Ministry of Health and Population workers who provide family planning services through a network of 3,800 clinics in all 27 provinces.

--The "Healthy Mother/Healthy Child" project, which focuses on in-service training for physicians, nurses and social workers, includes anti-FGM/FGC activities. Recent activities included preparation of a short documentary video featuring testimonials against this practice by five women for use in group discussions, as well as an accompanying guide for facilitators. The Child Survival Project that preceded the "Healthy Mother/Healthy Child" project incorporated information on the hazards of the practice into training courses for TBAs who frequently perform the procedure. Between 1985 and 1996 approximately 14,000 traditional TBAs, located throughout Egypt, received this training.

--A USAID grant to the Research, Action and Information Network for Bodily Integrity of Women (RAINBO) supported work with Egypt's FGM/FGC Task Force to develop training materials, including a manual with a major section on common beliefs and misconceptions about the practice, for community workers with a low level of literacy.

--USAID has provided funding to a UNICEF safe motherhood program with a major component on this practice; a Center for Development and Population Activities (CEDPA) project aimed at eradication of this practice in Fayyoun province and a project with CEDPA and the Coptic Evangelical Organization for Social Services to produce and air video programs on the harmful effects of this practice and the importance of eradicating the practice.

The U.S. Embassy's Participating Agency Support Agreement program funded several workshops and publications for public awareness on this practice by the ISIS Center in Aswan in 1999-2000, as well as a series of health awareness workshops (including anti-FGM/FGC materials) for adolescent girls by the Egyptian Women's Medical Association in 2000.

Egyptian activists working on the subject are beginning to shift efforts from an approach based on health concerns (that appears to have caused parents to resort increasingly to doctors rather than TBAs to perform the procedure), to one based on bodily integrity and women's status. Activists also are focusing on transforming the attitudes of entire communities rather than just of individuals, due to families' continuing concern about marriageability for their daughters.

The Coptic Evangelical Association for Social Services is one NGO that has had success with focusing on eradicating this practice one village at a time.

PROTECTION:

The government remains committed to eradicating this practice and is supportive of the many efforts of Egyptian and international NGOs in this regard. The issue of protection does not arise often as girls are subjected to this practice at a young age (generally age seven to twelve).

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN ERITREA

PRACTICE:

Type I (commonly referred to as clitoridectomy), Type II (commonly referred to as excision) and Type III (commonly referred to as infibulation) are the forms of female genital mutilation (FGM) or female genital cutting (FGC) practiced in Eritrea. Of the women who have undergone one of these procedures, one-third has been infibulated. Muslims and Christians alike practice FGM/FGC.

INCIDENCE:

According to a 1997 Demographic and Health Survey of 5,054 women nationally, 90 percent of women in Eritrea have undergone one of these forms of FGM/FGC. Most girls have this procedure performed while they are under the age of seven. Christian highlanders carry out the procedure on their daughters when they are 40 days old. Muslims, who practice Type III, carry out the procedure one-week after birth. If a mother cannot find an appropriate person to perform the procedure, however, the daughter might have to wait several years for it to take place.

In some ethnic groups, Type III is nearly universal. More than 90 percent of women have been infibulated among the Hedariib, Nara, Tigre, Bilen and Afar ethnic groups. In other groups, fewer women have experienced this extreme procedure (41 percent among the Saho; 31 percent among the Kunama and one percent among the Tigrigna). Type III is almost non-existent in the Southern and Central zones of the country.

The Tigray ethnic group (which comprises 30-40 percent of Eritrea's population) performs one of these procedures on girls between the ages of five and seven years. The procedure is generally not performed in Eritrea after the age of seven.

According to the survey, educated women living in Asmara and other large cities and women who are ex-fighters in the war of independence, are least likely to have their daughters undergo this procedure.

ATTITUDES AND BELIEFS:

Most of those who practice FGM/FGC believe it is a religious requirement. The high prevalence is also due to family and social pressures. Grandmothers are a particular source of pressure for continuing the practice.

There is a widespread belief that women who have not undergone this procedure will be promiscuous. In some cases in which a child's parents have refused to submit their daughter to it, the grandmother has had it done against the parents' wishes.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood.

Unless performed in a medical setting, these procedures are usually performed without the use of anesthesia.

OUTREACH ACTIVITIES:

The Eritrean People's Liberation Front (EPLF), which led the fight for independence and became the government in 1991, has worked since 1988 to eradicate this practice. Thirty percent of the fighting force during the struggle for independence was women. These women have been vocal in articulating their views that women sacrificed during the fighting, not to re-establish traditions harmful to women, but to protect the status of women within society.

The government has enlisted the leaders of Eritrea's largest religious groups in its campaign against this practice. Because most of those who practice FGM/FGC believe it is a religious requirement, Muslim and Christian leaders explain that it is not a part of either religion.

The National Union of Eritrean Women teaches midwives about the harmful health effects of the practice. This project compliments the campaign of the Ministry of Health. The National Union of Eritrean Youth and Students also conducts anti-FGM/FGC campaigns among the young people.

Public awareness about the health consequences of this practice is low. Therefore, publicizing the health effects is one of the main thrusts in the eradication campaign.

In 1996, the Ministry of Health, on behalf of the government, issued its primary health care guidelines articulating government policy on the practice. The government is committed to eliminating this practice and other harmful traditional practices affecting women. Government policy is that

components of women's health care include the prevention of practices such as these. It seeks to provide treatment, counseling and rehabilitation for women who suffer negative consequences as a result of this practice. It also said that unsafe traditional practices would be discouraged by legislation and by educating communities and groups that perform traditional practices.

The Ministry of Health is the primary organization responsible for eliminating these practices. It provides in-service training to all primary health care coordinators from each zone on FGM/FGC and provides each zone with training materials such as visual aids and documents about this practice.

In October 1996, the Health Ministry sponsored a safe motherhood workshop, of which one theme was the negative health impacts of FGM/FGC. It has also worked with the United States Agency for International Development (USAID), the United Nations Children's fund (UNICEF) and the United Nations Population Fund (UNFPA) to design a national and local level campaign to discourage the practice.

In addition to the government's own efforts carried out by the Ministry of Health, it actively supports the eradication activities carried out by the youth and women's organizations. These organizations are supported by the government as they were formerly part of the EPLF during the war for independence.

LEGAL STATUS:

There is no law against FGM/FGC in Eritrea. The government decided not to outlaw the practice for fear this would drive the practice underground.

During the independence struggle, the EPLF tried to prohibit the practice in areas that it controlled. Parents responded by having the procedure performed clandestinely and avoiding EPLF-run health clinics. Some women gave birth in the bush and infant girls were denied health care by their parents. A number of women and girls died as a result. The failure of this prohibition policy convinced the government to focus on education and persuasion as a means of eliminating this practice.

PROTECTION:

Since the procedure is not performed on girls over the age of seven, the issue of women or girls seeking protection from this practice does not arise.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN ETHIOPIA

PRACTICE:

Type I (commonly referred to as clitoridectomy) and Type II (commonly referred to as excision) are the two most common forms of female genital mutilation (FGM) or female genital cutting (FGC) practiced among Ethiopian women and girls, Type II being the most common. Type III (commonly referred to as infibulation) is practiced in the eastern Muslim regions bordering Sudan and Somalia. Type

IV (referred to as "Mariam Girz" in Ethiopia) is practiced mainly in the Amhara region. These practices cross religious boundaries, including Christians, Muslims and Ethiopian Jews (Falashas).

INCIDENCE:

In 1997/1998 the National Committee on Traditional Practices in Ethiopia (NCTPE) carried out a national baseline survey to determine the prevalence of this practice. Some 44,000 people were interviewed in a study reaching 65 of Ethiopia's 80 ethnic groups (urban and rural) in all ten regions of the country. The published results show 72.7 percent of the female population have undergone one of these procedures.

Regional statistics of the prevalence from the survey are: Afar Region – 94.5 percent; Harare Region – 81.2 percent; Amhara Region – 81.1 percent; Oromia Region – 79.6 percent; Addis Ababa City – 70.2 percent; Somali Region – 69.7 percent; Beneshangul Gumuz Region – 52.9 percent; Tigray Region – 48.1 percent; Southern Region – 46.3 percent.

Type I, often called the "sunna circumcision" in Ethiopia, is commonly practiced among the Amharas, Tigrayans and the Jeberti Muslims living in Tigray. The Gurages, some Tigrayans, Oromos and the Shankilas practice Type II. Type III, the most drastic and harmful form, is common among the Afar, the Somali and the Harari. Type IV, called "Mariam Girz", is practiced mainly in Gojam in the Amhara region.

A number of groups do not practice any of these forms. These are the Bengas of Wellega, the Azezo, the Dorze, the Bonke, the Shama and some population groups in Godole, Konso and Gojam.

ATTITUDES AND BELIEFS:

Cultural practice encourages women to want to undergo one of these procedures. It is often associated with positive attributes such as gaining respect within the village and becoming a woman. Most importantly, girls who have not undergone one of the procedures are considered more likely to be promiscuous and, therefore, unworthy of marriage. The belief also exists that external female genitals are unclean.

Some use religion as the basis for their justification in performing these procedures, despite the fact they are not required by either the Quran or the Bible. Some Coptic Christian priests refuse to baptize girls who have not undergone one of the procedures.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are then bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

TYPE IV:

Type IV includes the pricking, piercing or incision of the clitoris and/or labia. In Ethiopia the "Mariam Girz" involves blood letting with a sharp needle performed on girls with a stunted clitoris who are assumed to have been already circumcised by St. Mary.

The type of procedure and the stage in a woman or girl's life when it is performed vary according to regions of the country. It may take place eight days after birth, at any time between the age of seven and the onset of puberty, or just before marriage. Women practitioners perform the procedure. It is generally performed without the aid of anesthesia.

OUTREACH ACTIVITIES:

The government has created an atmosphere conducive to the eradication of this practice. It has encouraged the work of non-governmental organizations (NGOs). For example, the NCTPE has signed a tripartite agreement with the Disaster Prevention and Preparedness Commission and the Ministry of Health to undertake activities in the campaign against traditional practices harmful to the health of society in general and women and children in particular. The regional governments provide much in-kind support to NGOs such as use of conference halls, vehicles and teaching aids all free of charge.

The government is working to discourage these practices through programs in the public schools. Ethiopia's Federal Institute for Curriculum Development and Research (ICDR), working under the aegis of the Ministry of Education, has mandated that regional bureaus include materials discouraging harmful cultural practices, including FGM/FGC, in primary school curricula. Primary school children are taught to differentiate between "good culture" and "bad culture" beginning in grade four. According to the ICDR, "good culture" includes architecture, arts, literature, music and food traditions, whereas "bad culture" includes practices such as FGM/FGC. Schools have used anti-FGM/FGC curricular materials since 1994. The Education Ministry is conducting a study to determine what effects these materials have had on local practices.

Since the 1991 fall of the Communist "Derg" regime and the new government's promulgation of a National Policy on Women, a women's desk has been established within each ministry of the government to give moral support to the anti-FGM/FGC campaign.

The NCTPE, which was set up in 1987, is a chapter of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC). One of its objectives is to discourage and eradicate all forms of harmful traditional practices, including FGM/FGC. The IAC was given permission to establish its regional headquarters permanently in Addis Ababa.

The NCTPE carries out a wide range of activities to inform women about the health problems associated with this practice. Its activities include production and distribution of teaching materials, workshops throughout the country, activities with refugees and returnees, symposia to raise awareness for the media, teaching to raise awareness in secondary schools and research. In 1997, numerous informational activities about FGM/FGC were carried out by its regional branch offices throughout the country. It produces information materials such as posters, T-shirts and bumper stickers in order to raise public awareness about the harmful effects of the practice.

The NCTPE has received financial support for its education activities from the Embassies of the United States and the Netherlands. In 1995/1996, the U.S. Embassy through its Democracy and Human Rights Fund (DHRF) provided a grant of US\$56,000 to NCTPE for educational materials, training activities and purchase of technical equipment for teaching aids.

The NCTPE is divided into three sub-committees: education materials, research and fund raising. It works hand in hand with the Women's Affairs Bureau in the Prime Minister's office. It also works with the support of the Italian Association for Women in Development (AIDOS), Radda Barnen-Ethiopia and the United Nations High Commissioner for Refugees (UNHCR).

The NCTPE tackles this practice as a health issue, rather than a human rights issue. Because the practice stems from culture and tradition, simply telling people that it is “bad” or “a human rights abuse” would not be effective. It has opened ten branch offices in the regions of the country. These offices are particularly active in the Afar, Somali, East Oromia and Harare regions where the most extreme form, Type III, is practiced.

NGOs have contributed to putting the subject on the political agenda by concentrating on information, sensitization and capacity building at the grassroots level. They have targeted groups thought to be influential such as teachers, religious leaders, health practitioners, traditional birth attendants (TBAs), women’s and youth representatives and local government officials. They also focus on teaching school children about the adverse health effects related to this practice. Program activities consist of showing videos, distributing posters, holding seminars and follow up evaluations.

Positive First Results: Outreach efforts by the NCTPE have had some positive effects. Two years after the NCTPE had conducted a seminar on this subject in Wellega, one former excisor said she had been so affected by the seminar she changed her livelihood. She now washes and irons clothes for a living. In another case in a school in Addis Ababa some girls who had written a report with the NCTPE’s help on the harmful effects of the practice, learned that four of their classmates were going to be subjected to it. They enlisted the help of a teacher who had undergone anti-FGM/FGC training. By threatening to expel the four girls if they were subjected to this practice, the teacher was able to prevent it from happening.

Some religious leaders have started preaching that this practice has no basis in the Bible or Quran and, in fact, has negative health effects. In September 1998, Christian and Muslim leaders publicly denounced this practice.

Press conferences, articles and short messages have been used to disseminate information about this practice. Since 1995, short radio messages and spots transmitted through the education radio programs to school communities and general audiences have been used to create awareness about the negative effects. The U.S. Embassy provided a DHRF grant of US\$25,000 to the NCTPE in 1999 to fund a National Media Campaign on FGM, Early Marriage and Abduction.

LEGAL STATUS:

The government’s population policy, health policy and women’s policy all promote eradication of harmful traditional practices, including FGM/FGC.

This practice is not specifically illegal in Ethiopia. However, the 1995 Constitution and the 1960 Penal Code provide a legal basis for prohibiting harmful traditional practices. Article 35, Section 4 of the Constitution states that “Women have the right to protection by the state from harmful customs. Laws, customs and practices that oppress women or cause bodily or mental harm to them are prohibited.” In the 1960 Penal Code, there is a prohibition against torture and the cutting off of any body parts. This provision is interpreted by some as prohibiting this practice.

The Criminal Code is currently being revised. The Ethiopian Women Lawyers Association (EWLA) has focused its efforts on updating federal laws regarding women’s rights, including writing provisions into the new Criminal Code that will make FGM/FGC a crime. The U.S. Embassy has provided DHRF grants to EWLA in its efforts to change laws affecting women’s rights, including this practice.

The 1993 national policy on Ethiopian women states that “Ethiopian women are victims of circumcision and other harmful practices...such harmful customs and practices must be eliminated, for they stand in the way of progress and endanger lives. They should not be allowed to perpetuate.” The policy further describes strategies: “The Government, with cooperation from the peoples of Ethiopia, shall facilitate conditions conducive to the informing and education of concerned communities about such harmful practice as female circumcision.”

Discussions with government officials and NGOs active in the eradication of these practices indicate that the legal provision for prohibiting harmful traditional practices and the policy statements against them are not, as a practical matter, enforced. The practice is, however, officially discouraged by statements and actions of the government, which has been very supportive of the NCTPE in its campaign to eradicate this practice.

PROTECTION:

There are no documented cases of women going to court over or seeking protection against this practice. We are unaware of any groups or organizations that provide protection to women or girls who wish to avoid it.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN THE GAMBIA

PRACTICE:

Type I (commonly referred to as clitoridectomy) and Type II (commonly referred to as excision) are the most common forms of female genital mutilation (FGM) or female genital cutting (FGC) widely practiced in The Gambia. Type III (commonly referred to as infibulation) is practiced among only a small percentage of women and girls. Type IV (described in The Gambia as vaginal sealing) is also practiced. These practices are rooted in tradition and custom and cross ethnic, religious and cultural boundaries.

INCIDENCE:

The estimated percentage of all women in The Gambia who have undergone one of the forms of FGM/FGC ranges from 60 to 90 percent. The Foundation for Research on Women's Health, Productivity and the Environment (BAFFROW) reports that seven of The Gambia's nine ethnic groups practice one of these forms. Nearly all Mandinkas, Jolas and Hausas (together 52 percent of the population) practice Type II on girls between 10 years and 15 years of age. The Sarahulis (nine percent of the population) practice Type I on girls one week after birth. The Bambaras (one percent of population) practice Type III, which takes place when girls are between 10 years and 15 years of age. The Fulas (18 percent of the population) engage in a practice analogous to Type III that is described as "vaginal sealing" or Type IV on girls anywhere between one week and 18 years of age.

The Wolofs, Akus, Sereres and Manjangos (together 16 percent of the population) generally do not practice any of these forms. However, if a woman marries a member of an ethnic group that engages in this practice, she may be forced to undergo the procedure prior to marriage.

Of those who have undergone any of these procedures, twenty percent are below the age of five and fifty percent are between the ages of five and eighteen, with the average being approximately age twelve. The urbanized areas of the western division have a high concentration of ethnic Wolofs who do not practice any of these procedures.

Although statistics are lacking, one Gambian doctor who practiced medicine in The Gambia for over 20 years and later became the regional director of the World Health Organization (WHO),

documented that between 300 and 400 women died during childbirth every year from complications attributable to Type III or Type IV.

ATTITUDES AND BELIEFS:

It is generally the older women and excisors who are the major force behind maintaining the practice. The enticement of a big party, festive cooking and new clothes are commonly used as incentives for a girl to undergo the procedure.

In some cases, older women have been known to pursue a reluctant young woman and force her to undergo the procedure. It is difficult for a young woman to resist in the face of powerful extended family members should she decide not to. Occasionally the procedure is performed without the parents' consent. Rural women in groups that practice any form of FGM/FGC, strongly support the practice.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. Thorns are used to stitch the vaginal opening. The girl or woman's legs are then bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

It is estimated that about seven percent of girls undergo some form of this severe and dangerous procedure.

TYPE IV:

A form analogous to Type III, but described as "sealing" in The Gambia, is also practiced. Sealing involves the removal of the clitoris and the labia minora, followed by sealing the vaginal opening with clots of blood or herbal powder leaving only a small opening, about the diameter of a matchstick, for urination and menstruation. The legs are forced to stay tightly together during the period of convalescence (about 40 days) allowing the raw vaginal tissue to fuse.

A woman of the blacksmith's class who is believed to be gifted with knowledge of the occult traditionally carries out these procedures. Various instruments are used. Fingernails have been used to pluck out the clitoris of babies in some areas of the country. The procedure is often performed by a village excisor without the use of anesthesia. Instead, several women hold the girl or woman down while the cutting takes place.

OUTREACH:

There is a vested interest in continuing this practice in The Gambia. Many of the excisors are traditional practitioners or trained health attendants. They supplement their income with the money and

other articles they receive from work as excisors. In fact, the income they earn from performing this procedure is often higher than what they earn as midwives or nurses. Their social status also improves as an excisor.

The Gambia Committee against Traditional Practices (GAMCOTRAP) is the National Committee of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in the country. It has the lead role in sensitizing the public about the harmful effects of traditional practices such as FGM/FGC. It uses various strategies at the grassroots level using indigenous modes of communication and local languages.

GAMCOTRAP has organized training workshops and programs, including video viewing, to provide information on the harmful effects of this practice. It has directed its campaign to eradicate this practice at women, community leaders, youth and children. It has carried out programs on the harmful effects of the practice for traditional birth attendants (TBAs) in a number of villages. Workshops held during a women's week in The Gambia reached at least 5000 women. Lectures are held around the country to reach the entire populace. As a result, the once taboo subject is now openly discussed. GAMCOTRAP has also tried to reach school children through use of audio-visual materials and theater. It has used the media. It is also developing new strategies to provide excisors with alternate ways of earning a living.

A Symposium for Religious Leaders and Medical Personnel on FGM as a Form of Violence was organized by GAMCOTRAP. This resulted in the Banjul Declaration of July 22, 1998, which declared that the practice has neither Islamic nor Christian origins or justifications and condemned its continuation.

Founded in 1991, BAFFROW was established to carry out projects and research in the health and environment areas. It is aimed at community health promotion, along with changing many of the puberty rituals. It also focuses at providing alternate sources of income for excisors.

BAFFROW aims at 100 percent eradication of FGM/FGC while respecting the importance of the social and cultural traditions associated with the rites of passage to womanhood. It begins its work at the community level and, in a process that sometimes takes several years, gains the confidence of the village leaders, religious leaders, elders and excisors. Only then does it begin informing the community about the health risks of these procedures. It has had slow but steady success in its efforts.

BAFFROW also developed a comprehensive curriculum tailored to each ethnic group's social rites and customs. The focus of this curriculum is "initiation without mutilation." It was developed in concert with key members of each ethnic group including excisors for use in the schools.

The government's stance on this practice is unclear. In recent years, the government has publicly supported efforts to eradicate this practice and to discourage it through health education. Although the government recognized that the physical aspects of certain social and cultural practices present health risks and that medical research has documented the health risks of this practice, the government's primary concern was that the issue be addressed with all due sensitivity. At one time an article in the government's newspaper indicated that it supported the eradication of this practice and supported non-governmental organizations' (NGOs) efforts that proceed in "a gradual, convincing and tactful manner."

In July 1997, the Vice President, in addressing the National Assembly on this issue, stated that the government policy is "to discourage such harmful practices". This came a week after the Director of Information and Broadcasting ordered a ban on all anti-FGM/FGC radio and television programs. An international campaign against the directive ordering the ban ensued. The government has now stated that issues of reproductive health such as FGM/FGC, can be discussed on national radio and television networks. NGOs are allowed to use government media to address this issue.

In 1999, however, President Jammeh announced that The Gambia would not ban these practices. He also stated that FGM/FGC was part of Gambian culture. Several members of the National

Assembly and the Supreme Islamic Council have publicly supported continuation of FGM/FGC. The Vice President, on the other hand, has voiced support for reform.

In Fiscal Year 1999, the U.S. Embassy, through its Self-Help Program, provided over US\$10,000 to GAMCOTRAP to aid its program objectives to eliminate harmful traditional practices such as FGM/FGC.

One of the results of the extensive outreach efforts in the country has been that the topic is now an issue that concerned Gambians are willing to address publicly. Articles regularly appear in the local papers and opposing views on the subject are debated in editorials and letters to the editors. This is a beginning. At the same time, it is too early to document any decline in the practice.

LEGAL STATUS:

There is no law in The Gambia that specifically outlaws this practice. There have been no court cases concerning this issue.

PROTECTION:

Despite several outreach groups in existence, we are not aware of any cases where women have sought protection from the practice.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN GHANA

PRACTICE:

The form of female genital mutilation (FGM) or female genital cutting (FGC) most commonly practiced in Ghana is Type II (commonly referred to as excision). Other forms, such as Type I (commonly referred to as clitoridectomy) and Type III (commonly referred to as infibulation) are also practiced. The extent of the practice in Ghana as a whole is limited. These forms are generally practiced among a few groups in northern Ghana. There are also some migrants from neighboring countries who now practice it in southern Ghana.

With strong government commitment, extensive outreach by non-governmental organizations (NGOs), and a general receptivity to abandoning the practice, it is widely believed to be on the decline among the groups that practice it.

INCIDENCE:

FGM/FGC is most prevalent in the Upper East Region. It is also practiced regularly in remote parts of the Northern Region, Upper West Region and northern Volta Region. In the southern part of Ghana it is practiced among migrants from the northeastern and northwestern parts of Ghana, from Mali, Togo, Niger, Burkina Faso and other neighboring countries. It crosses religious boundaries. Practitioners of various religions perform FGM/FGC.

Studies conducted in 1986 and 1987 showed the practice to exist mainly among the following ethnic groups in the far northern part of the country - Kussasi, Frafra, Kassena, Nankanne, Bussaure, Moshie, Manprusie, Kantansi, Walas, Sissala, Grunshie, Dargati and Lobi.

A number of studies over the past several years have been conducted producing differing estimates of the percentage of women who have undergone this procedure. In 1998, the Gender Studies and Human Rights Documentation Center estimated that it had been performed on 15 percent of the Ghanaian female population. The United Nations Population Fund (UNFPA) recently funded a study conducted by Rural Help Integrated, an NGO providing reproductive health care services in the Upper East Region. The study found that FGM/FGC had been performed on 36 percent of the Upper East Region's female population and estimated that between 9 and 12 percent of Ghanaian women nationwide had undergone the procedure.

In 1996, Amnesty International Ghana, together with the Association of Church Development Projects, estimated that 76 percent of all women in the Upper East, Upper West and Northern regions had been excised. They cited several cities in these regions where it is still widely practiced: Kasena-Nankana, Bolgatanga, Bawku East and Bawku West in the Upper East Region; Bole, Mamprusi, West Walewale and Zabaugu-Tatale Kotokoli in the Northern Region; Wa and Nandom in the Upper West Region; and Kodjebi, Worawora and Jasikan in the northern Volta Region.

The World Health Organization (WHO) has provided seed money for research projects to develop statistics.

ATTITUDES AND BELIEFS:

The practice among some groups in Ghana appears to have few spiritual roots. It is not perpetuated by religion, but rather by traditional tribal beliefs. Some believe it leads to cleanliness and fidelity of the woman. Others believe it will increase fertility and prevent the death of first-born babies. It is also seen as a way to suppress a woman's sexual desires and make her less promiscuous.

Other common beliefs are that children born to uncircumcised women are stubborn and troublesome and more likely to be blinded or otherwise damaged if the mother's clitoris touches them during birth. In some areas the presence of a clitoris in women suggests she is a man and must be buried in men's clothing and the funeral performed as a man's when she dies. Uncircumcised women are regarded by some as unclean, less attractive and less desirable for marriage. Social or peer pressure is also cited as a primary reason that some undergo this procedure. Soothsayers in Animist religions often condone the practice.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are generally bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

In Ghana, the procedures are performed by excisors known as “wanzams” (both men and women), the elderly in society (i.e. the traditionalists), mothers or traditional birth attendants (TBAs) who use unsterilized instruments such as knives and razor blades. No anesthesia is used and no antiseptic precautions are taken when the same instrument is used on multiple girls. The procedure may be carried out during adolescence, at marriage, during a first pregnancy or on babies as young as seven days old. It is usually done in exchange for goods or small livestock, with a higher price if the girl is not a virgin.

The 1998 Gender Studies and Human Rights Documentation Center's study reported that 51 percent of all women who have been subjected to this practice had it performed before the age of one. They reported that 10 to 14 year olds make up the second most targeted age group with more than 85 percent of all procedures performed on girls under the age of 15. The usual age for undergoing this procedure follows regional patterns. In the Upper East, it is most often performed during puberty as a rite of passage to womanhood. Communities in the Upper West and northern Volta regions more often perform this procedure on infants.

OUTREACH:

The government of Ghana speaks out against this practice. Officials at all levels of the government speak out publicly against it. The current and former President, and the former First Lady, Ministers, the National Council on Women and Development (CWD), the Commission on Human Rights and Administrative Justice (CHRAJ) and several Members of Parliament and District Assembly men are strong voices on record opposing the practice. The media always places the practice in the context of regressive traditions, unbefitting of an ambitious nation. Articles covering officials' statements against the practice and efforts to inform the populace about the practice are common. NGOs target groups needing information on the subject.

The commitment of government officials and the media has created an environment supportive of the efforts of NGOs. The most successful of the programs to date have been the collaborative efforts of the Ghana Association for Women's Welfare (GAWW) and the Muslim Family and Counseling Services (MFCS). GAWW, founded in 1984, is a charter member of the IAC (Inter-African Committee on Harmful Traditional Practices Affecting the Health of Women and Children). It believes that other means, in addition to legislation against FGM/FGC, are needed to totally eradicate the practice. It believes education at the grassroots is needed to change tradition, superstitions and beliefs. GAWW brings resources including brochures, graphic educational films and models of the female genitalia to illustrate the procedures.

MFCS makes these efforts more effective because Islam and its leaders (who are males) are highly respected in the communities where FGM/FGC is practiced. The Director of MFCS, is himself a learned Quranic scholar, an Imam and a village chief.

GAWW and MFCS have been successful and have received invitations to speak in communities about the practice. Many practitioners and community leaders have renounced the practice. GAWW and MFCS have worked with local leaders (community, ethnic and political) to organize and conduct their workshops. They have given these leaders prominent roles in the process, recognizing their importance in the communities, to assure their support.

This groundwork has made the entire community receptive and has assured attendance at GAWW/MFCS workshops that are held throughout the country. Participants are given information on the harmful effects of this practice, the laws prohibiting the practice and the absence of Quranic imperatives for it. A very graphic film shows the procedure and consequences. The film has been very popular in getting the message across. All topics are addressed in an open forum where questions and comments are encouraged.

In an effort to provide continuing vigilance and follow up, the community leaders are encouraged to form watchdog groups from their own community. Local Imams are asked to speak out against the practice. Voluntary watchdog committees, 18 in Ghana, have been organized. These groups keep their

ears open and approach those involved in impending FGM/FGC ceremonies. They intervene by notifying the police if necessary and even offer refuge to those wanting to avoid the procedure.

In addition to GAWW's collaborative effort with MFCS, GAWW members are active on a number of other fronts. They work with health officials to research the relationship of this practice to HIV infection and other sexually transmitted diseases. They consult with the Ministry of Education on incorporating education about this practice into the public school health curriculum. They conduct workshops to inform school health teachers about the detrimental health effects of the practice. GAWW also conducts workshops for midwives and TBAs and collaborates with the Red Cross Mother's Club to incorporate education about FGM/FGC into their reproductive health education program.

GAWW has organized workshops for former excisors to help them branch out into other work. Many have given up their work but now need help from NGOs on alternative means to earn a living. WHO, in cooperation with GAWW and MFCS, toured 210 villages in the Volta Region in early 1997 and identified 18 practitioners to provide information and instruction about this practice.

GAWW is very active in northern projects. In 1997, it held a series of workshops on the harmful health effects of the practice in the Volta and Upper East and Upper West regions. Workshops were also held in Jasikan, Kadjebi and Worawora in the Volta Region with 420 participants. Committees were formed after each workshop to ensure follow up. In the Upper East and Upper West regions, workshops were held for police, health workers, students and educators. The primary focus was the law making the practice a criminal offense.

The U.S. Agency for International Development (USAID) provides financial support to the Navrongo Health Research Center's efforts to bring reproductive health education and instruction about FGM/FGC to rural women and girls. Through the Center for Development and Population Activities (CEDPA), USAID supports MFCS' Youth Reproduction Health Project in Greater Accra and the Eastern Region. The project incorporates information and instruction about FGM/FGC into their programs.

In 2000, the U. S. Embassy's Democracy and Human Rights Fund awarded a grant to the Rural Women Association for workshops on this practice in rural communities in the Upper East Region. The Peace Corp in the north has incorporated information about this practice into their classroom lessons on reproductive health and in training courses for school health teachers.

LEGAL STATUS:

In 1989, the head of the Government of Ghana, President Rawlings, issued a formal declaration against FGM/FGC and other harmful traditional practices.

Article 39 of Ghana's constitution provides in part that traditional practices that are injurious to a person's health and well-being are abolished.

In 1994, Parliament amended the Criminal Code of 1960 to include the offense of FGM/FGC. This Act inserted Section 69A that states:

“(1) Whoever excises, infibulates or otherwise mutilates the whole or any part of the labia minora, labia majora and the clitoris of another person commits an offense and shall be guilty of a second degree felony and liable on conviction to imprisonment of not less than three years.

(2) For the purposes of this section 'excise' means to remove the prepuce, the clitoris and all or part of the labia minora; 'infibulate' includes excision (Type II) and the additional removal of the labia majora.”

There have been seven arrests under the Act since 1994 and at least two practitioners have been successfully prosecuted and convicted. In March 1995, police arrested and charged the practitioner of

FGM/FGC on an eight year old girl and the parents of the girl under the law. In June 1998, a practitioner was sentenced to three years in prison for having performed this procedure on three girls.

There is no central record of arrests and convictions or any independent study to show the impact of the law.

There is the opinion by some that the law has driven the practice underground.

PROTECTION:

The law in Ghana protects an unwilling woman or girl against the practice, but there is little real protection to turn to in many rural areas. All levels of government have come out strongly against this practice. Advocacy groups work to eradicate it. There is a history of enforcement against those who practice or threaten to practice FGM/FGC. There are indigenous NGOs and watchdog committees throughout the country who are prepared to intervene and have stopped practitioners by going to the police when necessary. However, their reach does not extend to many remote communities. The police are willing to

and have cooperated to stop this practice from happening, but the ability of police to respond to remote communities in a timely or effective manner is severely limited.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN GUINEA

PRACTICE:

A variety of forms of female genital mutilation (FGM) or female genital cutting (FGC) are widely practiced in Guinea, including Type I (commonly referred to as clitoridectomy), Type II (commonly referred to as excision) and Type III (commonly referred to as infibulation). Some families are starting to opt for a slight symbolic incision on the genitals (Type IV).

These procedures are practiced without distinction as to ethnicity (Peul, Malinke, Soussou, Guerze, Toma, Nalou), religion (Islam, Christianity, Animism) or region of the country (Upper Guinea, Middle Guinea, Lower Guinea, Forest region). The only variation among the regions is the age at which a young girl undergoes the procedure.

INCIDENCE:

According to a 1999 Demographic and Health Survey of 6,753 women nationally, 98.6 percent of the women of Guinea have undergone one of these procedures. In Lower and Upper Guinea, girls are usually ten to twelve years of age when they undergo the procedure. In Middle Guinea girls are four to eight years of age.

A growing number of women and men oppose the practice. Some urban educated families are beginning to opt for a slight symbolic incision on the genitals rather than the complete procedure.

ATTITUDES AND BELIEFS:

These practices are firmly rooted in tradition. Girls generally live with their families until they marry. If a girl resists having the procedure, she would likely be mocked by others in her village and would have difficulty in finding a husband.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

Type II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

Type III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are generally bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

Type IV:

Type IV covers a number of methods including piercing the clitoris and/or labia. In Guinea, a slight symbolic incision on the genitals, rather than the whole procedure, is starting to be used by some families.

These procedures are generally performed without the use of anesthesia.

OUTREACH ACTIVITIES:

In Guinea, the organization that deals with traditional practices affecting the health of women and children is CPTAFE or Coordinating Body on Traditional Practices Affecting the Health of Women and Children (Cellule de Coordination sur les Pratiques Traditionnelles Affectant la Sante des Femmes et des Enfants). It is a well-established non-governmental organization (NGO) that came into existence in 1988. It is recognized by the government of Guinea. This organization collaborates with the government through the Department of Health and Social Affairs and Women's Affairs.

CPTAFE is a strong advocate. It has long worked to eradicate this practice in Guinea and to aid potential victims of it. Through its efforts, an article has been included in the Guinean Constitution that upholds the right to physical integrity of the person and condemns all forms of inhumane treatment.

The organization has produced four films on this practice, brochures and leaflets, radio and television programs, seminars, information and training for journalists, religious leaders, opinion leaders, former excisors, educators, entrepreneurs, cultural workers (such as Griots or traditional folklorists) and health professionals.

In 1997, CPTAFE collected and analyzed data for this practice carried out in Haute-Guinee and Moyenne-Guinee. A theater play about the harmful effects, "Tradition, Tradition" was performed before

members of the government and diplomatic corps, journalists, students and women's associations by a well known theatrical company of Guinea. After several performances, the play went on a national tour.

Regional committees of CPTAFE held cultural and sports events. A soccer tournament was held in the Labe region. The winning team received a cup engraved with the name of a prominent activist in the campaign against FGM/FGC, El Hadj Abdourhamane Diallo, who is the Imam of Labe. A conference was also held on this subject for the English Speaking Women's Association at the American Cultural Center in the capital, Conakry.

On March 17, 1997, the government initiated a 20 year (1996-2015) strategy to eradicate FGM/FGC in collaboration with the World Health Organization's (WHO) Africa regional efforts. The purpose is to reinforce and institutionalize efforts to date through better coordination and planning with NGOs using various communication and education mediums to inform the public about this practice.

The Head of State, the First Lady and other high-level government officials have spoken out in the public against this practice.

LEGAL STATUS:

This practice is illegal in Guinea under Article 265 of the Penal Code. The punishment is hard labor for life and if death results within 40 days after the crime, the perpetrator will be sentenced to death. No cases regarding this practice under the law have ever been brought to trial.

Article 6 of the Guinean Constitution, which outlaws cruel and inhumane treatment, could be interpreted to include this practice, should a case be brought to the Supreme Court. A member of the Guinean Supreme Court is working with the local CPTAFE on inserting a clause into the Guinean Constitution specifically prohibiting this practice.

PROTECTION:

In May 1996, CPTAFE was contacted by an NGO in France regarding the case of a Guinean woman who did not want to be repatriated to Guinea because she feared her two daughters would be excised. CPTAFE responded to the French NGO that the woman's fears were well founded as this procedure is often inflicted upon girls visiting relatives in Guinea.

In another incident, a girl was sent by her parents in France to Guinea to be excised. CPTAFE met the mother and daughter upon their arrival at the airport and held an informational counseling session at their home in Conakry. The girl was not excised.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN INDONESIA

PRACTICE:

Type I (commonly referred to as clitoridectomy) and less invasive procedures (Type IV) are the forms of female genital mutilation (FGM) or female genital cutting (FGC) practiced in Indonesia. The

practice is generally referred to as female circumcision in Indonesia. It occurs in parts of East, Central and West Java, North Sumatra, Aceh, South Sulawesi and on Madura Island, as well as in many other parts of the archipelago.

INCIDENCE:

There are no statistics on this practice in Indonesia. However, a study conducted in Jakarta and West Java, found most female children who were circumcised underwent ritualistic, largely non-invasive procedures.

The University of Indonesia's Women's Research Graduate Program conducted this study in October 1998. It surveyed 200 mothers, 100 living in an urban community in Jakarta and 100 living in a rural area in West Java.

According to the study, of 100 mothers in the Kemayoran community in Jakarta, 97 percent of their female children had been circumcised. Trained midwives or physicians circumcised the baby girls using a blood lancet or sewing needle to prick the clitoris until bleeding occurred. However, some midwives merely wiped the clitoris with alcohol and bethadine. This procedure took place when the girl was 40 days to five years old.

The 100 mothers surveyed from the rural West Java community of Cijeruk said 100 percent of their female children had been circumcised. Traditional birth attendants (TBAs) performed the procedure using small scissors, a razor blade or even a small piece of sharpened bamboo. The TBAs cut a small piece of the prepuce (clitoral hood) or the clitoris itself until bleeding occurred. This procedure was performed when the baby was about 40 days old.

It is a common practice among Muslim families from the Banten ethnic group in West Java, where it is largely a symbolic procedure. The practice is ceremonial, during which the clitoris of the baby or young girl is scraped or touched, often with the purpose of drawing several drops of blood. Sometimes a plant root is used symbolically and the girl is not touched at all.

These procedures usually take place within the first year, often on day 36 or 40 after birth, depending on local traditions. In some areas, however, it is performed on girls up to ten years of age. On Madura, the practice usually occurs when the baby girl is six months old.

The type of procedure performed in Indonesia, if any, is usually left to the discretion of local traditional practitioners who rely on local traditions. The procedure is often performed in a hospital in urban areas. Because procedures are largely symbolic, the incidence of complications is believed to be low.

ATTITUDES AND BELIEFS:

According to the study, Kemayoran community women in Jakarta believe that the practice is mandated or recommended by Islam. The more educated mothers believe the practice is "sunnah" (recommended or encouraged by the prophet Muhammad). The less educated mothers believe the practice is "wajib" (mandatory).

The rural mothers of the West Java community of Cijeruk said the procedure was performed according to sunnah and was meant to purify female babies. It was also regarded as a local custom and believed to promote good hygiene.

Some religious leaders believe that the removal or partial removal of the clitoris is beneficial to marriage because a woman would be more likely to remain faithful to her husband if she had no sexual drive. Some religious Islamic leaders consider this practice a mandate of Islam. Other religious leaders believe that this practice is recommended by Islamic teachings but not mandated.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

This procedure occurs on Madura Island, South Sulawesi and parts of East Java and Sumatra. Although there is disagreement over the prevalence of this practice, it appears to be on the decline.

TYPE IV:

Type IV includes the pricking, piercing or incision of the clitoris and/or labia. It also includes the scraping of the vaginal orifice or cutting of the vagina.

Various forms are practiced in different parts of Indonesia, especially where Muslim populations predominate. The method employed depends on ethnic, cultural and religious traditions.

OUTREACH ACTIVITIES:

The government included this practice as a gender issue in its National Action Plan to End Violence against Women, published in November 2000. This Plan commits the Ministry of Women's Empowerment and the Ministry of Religion to conduct research on religious teachings that impede women's rights. FGM/FGC heads the Action Plan's list of religious teachings requiring investigation and modification. The Government, the National Ulemas Council, religious leaders, women's groups and health practitioners are to develop guidelines for health practitioners and midwives on non-invasive techniques for this practice. An awareness campaign is planned.

Currently public awareness of this practice is low. The subject is not discussed in schools and rarely in the media. In 2000 an article on a ritualistic FGM/FGC ceremony in West Java did appear in an English language newspaper.

The National Ulemas Council supports eliminating female circumcision in stages. For now, it will support ritualistic, non-invasive forms of this practice. It has agreed under the Action Plan, to participate in joint efforts to develop guidelines for health practitioners and midwives on non-invasive female circumcision techniques.

Two women's rights groups are addressing FGM/FGC issues. These are the Convention Watch and the Indonesian Women's Coalition for Justice and Democracy. They believe that projects combining further study of this practice and an awareness campaign of this issue, especially directed at regions where invasive procedures are reported to occur, would help end this harmful practice. Convention Watch is currently working on a proposal for this.

The Convention Watch working group has also expressed interest in researching the prevalence and types of FGM/FGC that occur in Indonesia. They would like to extend the University of Indonesia's 1998 study to other regions in Indonesia, including Madura Island, West Sumatra and South Sulawesi.

LEGAL STATUS:

There is no national law against FGM/FGC in Indonesia. Customary law permits symbolic and small-cut incisions of the clitoris.

PROTECTION:

Since this practice usually takes place when the child is very young, the issue of protection does not arise.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN KENYA

PRACTICE:

Type I (commonly referred to as clitoridectomy), Type II (commonly referred to as excision) and Type III (commonly referred to as infibulation) are the forms of female genital mutilation (FGM) or female genital cutting (FGC) practiced to varying degrees in Kenya. Type I and Type II are the most common. Type III is found in the far eastern areas bordering Somalia. Studies indicate it is practiced mostly in rural areas, especially among those that have lower educational levels and/or subscribe to non-Christian faiths. It is, however, also practiced by some Christians and was practiced by Ethiopian Jews, who now live in Israel.

INCIDENCE:

In June 1999, the Ministry of Health prepared a National Plan of Action for the Elimination of FGM/FGC. Contained in the Plan were the results of a 1998 Demographic and Health Survey of 7,881 women nationally that showed 37.6 percent of Kenyan women had been subjected to one of these procedures. The study indicated that 38 percent of Kenyan women between the ages of 15 and 19 and over half of women above the age of 35 had been subjected to one of these.

It is reportedly practiced in varying degrees by some 30 of Kenya's 40 plus ethnic groups. It is not practiced among the two largest ethnic groups in Kenya's far West, the Luos and the Luhyas.

The Ministry of Health statistics by tribal affiliation are: Kisii - 97 percent; Masai - 89 percent; Kalenjin - 62 percent; Taita and Taveta - 59 percent; Meru/Embu groups - 54 percent; Kikuyu - 43 percent; Kamba - 33 percent; Miji Kenda/Swahili - 12 percent.

A 1992 survey conducted by the largest grassroots organization, Maendeleo Ya Wanawake Organization (MYWO), found that nearly 90 percent of the women over 14 years of age in the Kisii, Meru, Narok and Samburu districts had been subjected to one of these procedures. It is widely practiced among the Muslims of the northeastern provinces, particularly among the Somalis, Borans and Gabras. In its survey of the four districts, MYWO found that Type I is practiced in Kisii; Type II in Meru and Narok; and Type III in Samburu.

The practice is believed to be on the decline. This is attributed to public awareness campaigns to halt the practice and the ongoing efforts to promote alternative rites of passage to adulthood.

ATTITUDES AND BELIEFS:

Among the groups that practice FGM/FGC, it is universally thought that the procedure benefits girls. There is widespread belief among those who practice it, that ancestors will curse girls who have not undergone the procedure. Mothers and grandmothers are the most influential persons to determine if girls undergo one of these procedures. Supporters argue that tradition is necessary both to the social fabric and to the maturation of girls. Many believe that the cut reduces female promiscuity, ensuring virginity at marriage and marital fidelity.

Various beliefs are associated with the practice. The Akamba, for example, say that it helps women avoid difficulties in childbirth. In rural areas where it is practiced, girls who have not undergone the procedure are often told they will never get husbands, an effective scare tactic in rural Africa where there is discrimination against unmarried women. In some surveys, older men also reflect the traditional preference for wives who have undergone the procedure, while high school boys express preference for marrying girls who have not.

Supporters see the practice as integral to a girl's maturation because the ritual includes instruction about sexuality, relations with husbands, pregnancy, behavior and the importance of marrying outside the clan. This is usually the only such formal instruction a girl receives.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are generally bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

The procedures are generally carried out by traditional excisors on girls between the ages of 3 and 13 and without the aid of anesthesia. It is usually performed under unsanitary conditions in a village or woods. The procedure is frequently performed during puberty rites with the excisor using the same instrument on a number of girls without proper sterilization.

OUTREACH ACTIVITIES:

The Ministries of Health and Culture discourage this practice and encourage the adoption of alternative rites of passage to womanhood for young girls. The government recognizes the lack of a coherent national policy on this issue and encourages the enactment of legislation to eradicate the practice.

Many non-governmental organizations (NGOs) are actively trying to eliminate this practice through education, awareness campaigns, legislative lobbying and advocacy for alternative rites of passage to adulthood for young girls. Alternative rituals can include education by community elders, public or private ceremonies and retreat-style seclusion of young girls for several days. Some of the most active NGOs include Julikei International, MYWO, PATH (Program for Appropriate Technology in Health), Northern Aid and Womankind.

The Kenya National Committee on Traditional Practices, founded in 1990, had as one of its objectives to carry out research into which ethnic groups practice FGM/FGC. The National Committee was reorganized to become the Kenya National Council on Traditional Practices (KNCTP). It works in collaboration with other groups on this issue. KNCTP is part of an anti-FGM/FGC core group formed at the invitation of the United Nations Children's Fund (UNICEF) and the United Nations Development

Program (UNDP). Other members of this group are CARE/Kenya, the World Health Organization (WHO), PATH, the International Federation of Women Lawyers (FIDA) of Kenya and MYWO.

MYWO, the national women's organization closely aligned with the ruling Kanu party, is one of the most active Kenyan organizations working to eradicate this practice. It initiated a three-phase program to eradicate harmful traditional practices. It carried out quantitative research in 1991-1992 in four districts and is working with local communities to implement strategies that reflect the findings of their research. Messages about harmful practices are being integrated into health and other programs in the districts.

MYWO is opposed to outlawing the practice, arguing that making it illegal would not stop it but merely drive it underground and make it more difficult to control. Rather, MYWO has focused its program on informing the community on the dangers of the practice. MYWO has also developed alternative initiation rites that prepare girls for womanhood by instructing about sexuality but without *the cut* as a puberty rite of passage into womanhood. These alternative rites have been instituted in a number of villages with positive results.

Religious organizations have actively sought to eliminate this practice since the beginning of the 20th century. The Presbyterian Church of East Africa and various Protestant churches continue to raise awareness and to discourage the practice. The Catholic Church has also condemned the practice.

The United States, the Netherlands, Austria and Germany have supported NGOs and other organizations in the campaign against this practice.

The United States Agency for International Development (USAID) in Kenya has funded programs for research into and eradication of this practice in several targeted areas of Kenya. It provided technical assistance to indigenous health workers in developing a pilot intervention strategy. The approach is multisectoral in that it reaches entire communities - women and men, girls and boys, grandparents, midwives, traditional birth attendants, doctors, nurses, religious leaders and community leaders.

In the late 1990s, USAID funded Womankind, an organization working on a variety of women's issues, including FGM/FGC. In 1998, USAID also made a grant to the Federation of Women's Groups of Nyamira, which trains people to speak about the dangers of the practice and develops alternative rites of passage for young girls.

Through the Frontiers Project, USAID funded PATH (an American organization) to work with MYWO on introducing alternative rites of passage for girls in three districts in western Kenya. USAID also funded the Population Council's evaluation of the same program. These projects were funded between 1996-1999.

USAID also supports a Demographic and Health Survey conducted every five years and worked closely with the Ministry of Health to develop the National Plan of Action for the elimination of this practice.

Since July 1999, the U.S. Embassy, through its discretionary grant fund, has funded nine women's workshops on this issue. In the context of discussions on HIV/AIDS, the workshops address FGM/FGC. It is also expected to provide assistance for the Center for Rehabilitation and Education of Abused Women that, among other activities, lobbies for legislation to ban this practice.

In March 1997, UNICEF organized a meeting of donors, NGOs and UN agencies to share information and coordinate a campaign to eradicate this practice in Kenya. They agreed that while the practice should be made illegal, information, instruction and persuasion are the only effective tools to change the practice at the grassroots. Despite the fact this practice has been attacked as a traditional practice harmful to the health of women and girls, it is also seen as a gender issue that should be understood in its broader sense, involving a full range of women's training and employment efforts.

The many media houses in Kenya have written extensively about the health, psychological and social issues associated with this practice. The press has highlighted communities' efforts to welcome young girls into adulthood through alternative rites of passage. A growing number of radio stations (some using vernacular languages) have helped address the issue.

Schools have sought to educate students about the problems associated with the practice, particularly in the context of raising awareness about the HIV/AIDS virus and proper health practices. The Ministry of Education oversees the Federal Institute for Curriculum Development and Research. It requires regional education bureaus to include educational materials discouraging harmful traditional practices, including FGM/FGC, in primary school curricula.

LEGAL STATUS:

There are no laws making FGM/FGC illegal in Kenya. There are provisions in the Penal Code pertaining to "Offenses Against Person and Health" that might be applicable. However, there have been no arrests for FGM/FGC on the basis of these provisions. In November 1996, Parliament defeated a motion to make this practice illegal. In 1982 and 1989, President Moi issued Presidential decrees banning the practice.

The government prohibits the practice in government-controlled hospitals and clinics. In 1982, the Director of Medical Services instructed all hospitals to stop the practice, stating that he would prosecute medical professionals performing FGM/FGC under the Medical Practitioners and Dentists Act and the Nurses, Midwives and Health Visitors Act.

In 1990, the Minister for Cultural and Social Services announced at an international seminar in Nairobi, that it was the government's aim to outlaw this practice. The Director of Medical Services repeated this and demanded that all government hospitals and mission hospitals cease carrying out this practice. The Kenya National Family Welfare Center also abides by this directive. The government cooperates with eradication efforts conducted by international organizations and NGOs.

PROTECTION:

Although there are no laws against this practice, the government is cooperating with a dynamic and broad-gauged campaign against the practice across Kenya being waged by NGOs and donor organizations. There are currently no groups or organizations that specifically provide protection to women or girls who wish to avoid this practice. However, some churches and schools have offered occasional refuge to victims and potential victims of this practice.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN LIBERIA

PRACTICE:

The form of female genital mutilation (FGM) or female genital cutting (FGC) practiced in Liberia is Type II (commonly referred to as excision). It was customarily practiced by most ethnic groups in Liberia prior to the outbreak of civil war in late 1989.

In areas where traditional institutions were strong, the practice tended to be more frequent. The war, however, brought tremendous dislocation of the population and significantly disrupted rural life and traditional institutions which some believe has resulted in a substantial reduction of the practice.

INCIDENCE:

Exact figures are difficult to ascertain, but a significant portion of the female population has undergone Type II. Some estimates are that, in rural areas, approximately 50 percent of the female population between the ages of eight and eighteen had undergone this procedure before the civil war began. It was practiced within some, but not all of Liberia's ethnic groups. Not all girls in those ethnic groups that practice Type II, however, participate in the rites associated with it. For those who do, it is their passage from childhood to womanhood. (See section on Attitudes and Beliefs that follows.)

The major groups that practice it are the Mande speaking peoples of western Liberia such as the Gola and Kissi. It is not practiced by the Kru, Grebo or Krahn in the southeast, by the Americo-Liberians (Congos) or by Muslim Mandingos.

In the more urbanized and populated areas such as in Monrovia, whether or not it was practiced depended on education and class and how close the family's ties were to rural life. One well-educated female lawyer in Monrovia underwent the procedure just before she married because she came under strong pressure from an upcountry grandmother.

Many poor families did not engage in this practice because they could not afford for their daughter(s) to remain six months (and in some cases up to a year) in a secluded traditional school where girls were prepared and initiated into adulthood by older female members of the secret societies.

Many believe the civil war has caused a reduction in this practice, estimating that the incidence has dropped to as low as 10 percent. The war caused most of the population to flee to neighboring countries or become internally displaced. Social structures and traditional institutions, such as the secret societies that often performed this procedure as an initiation rite, were also undermined by the war.

With the civil war ended and traditional societies re-establishing themselves throughout the country, practices such as FGM/FGC are expected to increase again in rural areas for those groups for which it has been a significant and important rite of passage. The extent to which these practices might be revived to pre-war levels is yet unknown.

ATTITUDES AND BELIEFS:

The practice of FGM/FGC has been a part of custom and tradition in the more remote areas. However, among many of the educated and in the urban areas, the practice has not been as strong. It is performed during initiation rites into womanhood by older trained members of secret societies. It is difficult to obtain information on the actual rites as members are sworn to secrecy. Some girls have said they looked forward to the procedure and becoming a full member of society, while others have expressed their fear when learning that close friends had bled to death after the procedure was performed.

Because of the civil war in Liberia, it was not possible to hold special schools and initiation rites in rural areas as before. From 1990-1992, however, a large school operated in Monrovia on Bushrod Island behind the brewery. The school was destroyed in 1992 during a major attack on the capital.

Today there are three such small schools, reportedly the only ones in Liberia, operating periodically in Monrovia. Instead of six to twelve months in these schools, female initiates reportedly

spend a weekend in a Sande house. It is reported that the age of initiation into womanhood, which used to occur when the child was between eight and fourteen years of age, has dropped to between three and seven years of age. Children younger than three have sometimes been initiated.

TYPE II:

Type II is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris. The most severe form, Type III (commonly referred to as infibulation), is not practiced in Liberia.

This procedure is usually practiced without the use of anesthesia. Unsterile, crude instruments may be used if performed in the bush. A single instrument may be used on a number of girls.

OUTREACH:

In 1985, the Liberian National Committee, affiliated with the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) which was called the National Association on Traditional Practices Affecting the Health of Women and Children, was set up. It conducted research into the prevention of FGM/FGC and attitudes towards the custom. It also carried out awareness-raising meetings, trained volunteers and provided health training about the harmful effects of this practice. It collaborated with the Ministry of Health and Social Affairs in an effort to integrate awareness of the consequences of the practice into programs for mothers and childcare and primary health care.

During the civil crisis, the IAC National Committee continued to work informing women and girls about the harmful health effects of the practice. Members worked with rural women in displaced centers around Monrovia; students in secondary schools; religious leaders, women's groups and youth groups; and provided income generating training for a number of excisors. The Committee began restructuring in 1994. Its focus is on the spiritual aspects of the practice, using biblical backing through audio-visual aids. Efforts are being made to win support of youth groups and women's groups. The support of community leaders, elders, chiefs and government officials, however, is still lacking.

Another more recent group, the Liberian Action Network, also worked in the anti-FGM/FGC campaign. It focused on the social and health problems associated with the practice. In 1989, the group gathered information on the prevalence of the practice in the country. It recommended continual dialogue, information and public awareness programs, seminars, workshops and meetings. It also urged that the media be used to persistently address the people about the health consequences attributed to this practice.

Campaigns against FGM/FGC carried out in the media, newspapers and pamphlets had little apparent effect in stopping the practice during the pre-civil war period.

LEGAL STATUS:

There are no laws in Liberia that make this practice illegal. It might be covered under Section 242 of the Penal Code, however, that finds a person guilty of a felony and punishable for up to five years in prison if the person "...maliciously and unlawfully injures another by cutting off or otherwise depriving him of any of the members of his body..." No cases have been reported under this provision for the practice of FGM/FGC, however.

PROTECTION:

We are unaware of any cases where women have sought protection from being subjected to this procedure.

**FEMALE GENITAL MUTILATION (FGM)
or
FEMALE GENITAL CUTTING (FGC) IN MALI**

PRACTICE:

The most common forms of female genital mutilation (FGM) or female genital cutting (FGC) throughout Mali are Type I (commonly referred to as clitoridectomy) and Type II (commonly referred to as excision), despite the fact that Malian women's groups have been actively campaigning against this practice for over a decade. The more radical form, Type III (commonly referred to as infibulation), is practiced in some of the southern areas of the country.

The incidence of these procedures among the women varies very little by age, religion or level of education. A recent survey found that three-quarters of the women between the ages of 15 and 49 favored continuing this practice.

INCIDENCE:

A United States Agency for International Development (USAID) funded Demographic and Health Survey of 9,704 women aged 15 to 49 in Mali was conducted in 1999 jointly by the Malian government and a private firm. The report put the percentage of women in this age range that had undergone one of these procedures at 93.7 percent.

The Commission for the Promotion of Women estimates that as many as 96 percent of women and girls living in rural areas and 92 percent of women and girls living in urban areas have been subjected to one of these procedures. Of the various forms, between 80 and 85 percent of the women affected have been subjected to Type I or Type II.

The practice crosses religious, ethnic, age and geographic lines. Only among the ethnic groups in the north of the country is the prevalence low. The Muslim Songhai, Tuareg and Moor populations, in general, do not practice any form. This accounts for the low prevalence in the northern regions of Tombouctou and Gao - 9.3 percent of the women. These areas are also the most sparsely populated.

The practice is found among more than 95 percent of the women and girls in the southern half of Mali, predominately populated by the Bambara, Soninke, Peul, Dogon and Senoufo ethnic groups. These groups include Muslims and Christians, as well as Animists. In Bamako and Koulikoro in southern Mali, the rates reported are 95.3 percent and 99.3 percent respectively.

The actual practice varies according to ethnic group. In the past this practice was part of the marriage ceremony, the procedure performed on girls aged 14 or 15. The custom has changed and the age lowered. Some groups excise girls at an early age between birth and five years of age. It is common to subject girls as young as 20 days old to the procedure. The rationale is that wounds heal more effectively at a very young age. According to the Population Council, 37 percent of girls undergo the procedure before they reach school age.

Malian girls and women can, however, undergo the procedure at all ages. In some groups, such as the Dogon in the region of Mopti and the Senoufo in the region of Sikasso, the girls are initiated with

this procedure being part of the rites. It then becomes part of an age-group rite of passage to womanhood. Girls are excised as part of a celebrated puberty rite. They are then ready for marriage.

ATTITUDES AND BELIEFS:

This practice is so deeply rooted in tradition and culture that any challenge to it runs into strong social opposition and repercussions. Women who have not been subjected to one of the procedures or parents who refuse to subject their daughters to it face social pressures and potential ostracism from society. Often women who have not undergone the procedure cannot marry. Malian society considers an individual (male or female) to be a child until circumcised.

Some Bambara and Dogon believe that if the clitoris comes in contact with the baby's head during birth, the child will die. It is their deeply held belief that both the female and the male sex exist within each person at birth and it is necessary to rid the female body of vestiges of maleness to overcome any sexual ambiguity. The clitoris represents the male element in a young girl while the foreskin represents the female element in a young boy. Both must be removed to clearly demarcate the sex of the person.

Another extreme belief of the Bambara men is that upon entering an unexcised woman, a man could be killed by the secretion of a poison from the clitoris upon its contact with the penis. This folk belief acts as a rationale for clitoral excision.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are then bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

Female traditional birth attendants (TBAs) perform the procedure. They normally earn US\$2-\$5 for each procedure performed, which creates an economic incentive to continue the practice. This, in a country where the annual per capita income is around US\$300.

A special saw-toothed knife is commonly used to perform the operation. TBAs in rural villages have little access to methods for sterilization of the knife or sanitary materials to deal with excessive bleeding. The risk of hemorrhage and infection is high. One Malian doctor estimated that only about four percent of the operations are performed in hospitals by health professionals. Unless performed in a hospital, anesthesia is generally not used.

In some areas of the country, extended families excise all of the girls. If the head of the family or an influential member opposes the procedure, the girls in that family may be spared. In response to older girls objecting to the procedure, some families are excising girls at a younger age.

OUTREACH ACTIVITIES:

Outreach activities concerning this practice have been carried out for many years. The Centre Djoliba, a private humanitarian organization linked to the Catholic Church, has been working the longest on these activities. It focuses on scientific and applied research, training and interventions. Its Women's Program includes health information on the practice.

In 1984, the Comité Malien de Lutte Contre Les Pratiques Traditionnelles Nefastes (COMAPRAT) was established. It provided programs on the health effects of the practice for midwives, religious leaders, etc. It was later dissolved in the early 1990's following a change of government. However, a new association, the Association Malienne pour le Suivi et l'Orientation des Pratiques Traditionnelles (AMSOPT), was formed. This is the National Committee of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC). It has undertaken instruction of youth and religious leaders throughout Mali about the effects of this practice. It has also held projects for excisors and their assistants.

AMSOPT identifies victims of this practice and gives them medical assistance. It also creates income-generating activities for excisors. In 1997, it provided information and communication sessions in a large number of villages on the harmful health consequences of the practice. Networking activities with village leaders, men, women and Imams to inform them about the harmful effects were carried out. Focal persons were trained in the zone of Kangaba. Retraining and refresher courses were given to 90 focal persons in the zone of Sanankoroba. AMSOPT uses materials such as charts, slides, anatomical models and films in its training process. Theatrical groups and the media are also used to get the message across.

Before the one-party state was overthrown, the women's arm of the party was very active informing women about the dangers of the practice and discouraging it. Since 1991, women's groups have continued this work and urged that the practice be outlawed altogether. However, up to now, the official government response has been to support campaigns against the practice but not to outlaw it.

In December 1996, the government formed a National Action Committee to promote the eradication of harmful health practices against women and children. The Committee's mandate is to develop coherent strategies leading to concrete action against practices that harm women and children. The Committee engages in activities of information and public awareness, including production of audio-visual materials; training; promotion of research; legislation reform; and support of non-governmental organizations (NGOs) that combat these harmful practices.

The National Action Committee is comprised of government representatives from each Ministry, as well as representatives from NGOs, associations, national health and science research institutions and the religious community. The Commissioner for the Promotion of Women heads this Committee. The National Action Committee has established regional committees in Mali's eight regions that formulate local-level action plans and implement programs as set by the Committee.

The Malian government's Commission for the Promotion of Women and the local Population Council office sponsored a national seminar on strategies to eradicate FGM/FGC in Mali from June 17-19, 1997. Approximately 100 people participated, including the Malian Government Ministers of Health, Education, Justice and Tourism. The former National Assembly President, Ali Nouhoum Diallo, also attended and publicly called for a national law against these practices.

Strategies articulated at this seminar included a national law banning this practice in Mali; information and communication campaigns throughout the country; increased research on this practice and related medical and social implications; information and training for NGOs and government workers; the establishment of a center for the treatment of women who have undergone any of these procedures; the creation of a database for information on the practice; and the promotion of increased information exchange with other West African countries.

At this meeting, the Committee devised the first phase of the Plan of Action for the eradication of FGM/FGC by 2007. This phase is to take place between 1998 and 2002. It includes creation of the

database on the practice in Mali; development and implementation of programs to eliminate the practice; and better coordination between national and international organizations.

There is widespread agreement within the government that this practice needs to be eradicated. Government regional offices support eradication efforts by NGOs and associations at the village level. The government supports regional cooperation and has plans to establish an international center in Mali for research and dissemination of information on the practices. Islamic religious leaders, however, remain opposed to ending the practice. These leaders play a prominent role in most communities in Mali. Some political leaders fear these religious leaders who oppose the practice.

Since 1991, two of the most active groups in efforts to inform people about the practice have been the Association for Promoting the Rights of Women (APDF) and the Action Committee for the Rights of Women and Children (CADEF). Their efforts, however, vary from region to region.

In Segou, APDF sponsored a project for "excisors" or the women who perform FGM/FGC. It focused on giving the excisors an alternative way to make a living. It also encouraged former excisors to train and provide information to other excisors. APDF, for example, has offered the use of a grinding mill to former and current excisors to increase the value of their agricultural products such as millet on the local market.

CADEF also conducts information campaigns in Segou. More people are starting to talk openly about this subject and fewer parents are excising their daughters. CADEF and other groups have established information campaigns in the southern towns of Sikasso and Bougouni.

The National Women's Organization (NOW) organizes conferences and study groups on this practice. Radio Mali disseminates information on this and other harmful traditional practices in its Women and Development Program. The United States based Population Council, with an office in Bamako, is funding research studies and providing technical assistance to the National Action Committee in combating all forms of FGM/FGC.

Other NGOs working in the campaign against this practice include the Association de Soutien au Developpement des Activites de Population (ASDAP); Association des Femmes Educatrices (AFEM); Association des Femmes Juristes du Mali (AJM); Health Organization for Population and Environment (HOPE); and Cooperative des Femmes pour l'Education, la Sante Familiale et l'Assainissement (COFESFA).

Until 1997, NGO focus was regional. Now NGOs are beginning to coordinate their efforts in combating this practice. They campaigned actively throughout 1998. In Bamako excisors turned over their knives in highly publicized ceremonies sponsored by AMSOPT.

LEGAL STATUS:

FGM/FGC is not specifically illegal in Mali. There are provisions in the Penal Code outlawing assault and grievous bodily harm, however, which might cover this practice. The government of Mali in its National Plan for the Eradication of FGM/FGC by 2007 has stated that this practice may be prohibited under Articles 166 and 171 of the Penal Code covering voluntary strikes or wounds and harmful experimental treatments, respectively.

If a girl were excised against the mother's will (by a relative such as a grandmother, mother-in-law or co-wife) the mother could press charges under these provisions of the Penal Code. However, this option is virtually never used because traditional respect for family ties precludes bringing relatives to court.

As a result of the recommendations made at the June 1997 national seminar, the government charged the National Action Committee to submit draft legislation making these practices illegal in Mali to

the National Assembly. In October 1998, the Committee adopted a draft action plan against these practices for submission to the Ministerial Council. So far no law has been passed.

PROTECTION:

An influential head of the family could protect the daughter or daughters of the family from this practice. However, there is usually pressure exerted from other members of the extended family to perform the procedure. Under Malian custom, even if a mother refused to allow her daughter to be excised, another member of the family could have it performed without the mother's permission.

The government's policy until recently has been not to outlaw the practice. The rationale, according to some, was that girls who bled heavily after being excised might not be brought to the hospital for fear of legal repercussions and girls might bleed to death as a result if the practice was outlawed.

The Penal Code's provisions against assault and grievous bodily harm might provide some protection, although no attempts at prosecution for this practice have been reported. However, the legislation now being prepared to outlaw these practices should offer greater protection for those who oppose the practice.

Outreach groups working to eradicate the practice are only now starting to coordinate their activities in different regions of the country. Some have, in the past, provided shelter and intervention for women seeking to avoid this procedure, but there is no organized intervention available.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN NIGERIA

PRACTICE:

Type I (commonly referred to as clitoridectomy), Type II (commonly referred to as excision) and Type III (commonly referred to as infibulation) are the most common forms of female genital mutilation (FGM) or female genital cutting (FGC) practiced in Nigeria. Type IV is practiced to a much lesser extent.

The form practiced varies by ethnic group and geographical location. It crosses the numerous population groups and is a part of the many cultures, traditions and customs that exist in Nigeria. It crosses the lines of various religious groups. It is found among Christians, Muslims and Animists alike.

INCIDENCE:

With over 250 ethnic groups and an estimated population of 120 million, a national estimate of this practice is very difficult. The most recent survey is a 1999 Demographic and Health Survey of 8,205 women nationally. This survey estimates that 25.1 percent of the women of Nigeria have undergone one of these procedures.

According to a 1997 World Health Organization (WHO) study, an estimated 30,625 million women and girls, or about 60 percent of the nation's total female population, have undergone one of these forms.

A 1996 United Nations Development Systems study reported a similar number of 32.7 million Nigerian women affected. According to a Nigerian Non-Governmental Organization (NGO) Coalition study, 33 percent of all households practice one of these forms.

However, according to some Nigerian experts in the field, the actual incidence may be much higher than these figures. Leaders of the Nigerian National Committee (also the Inter-African Committee of Nigeria on Harmful Traditional Practices Affecting the Health of Women and Children [IAC]) have been conducting a state by state study of the practice.

This 1997 study by the Center for Gender and Social Policy Studies of Obafemi Awolowo University in Ile-Ife, was contracted in 1996 by a number of organizations including WHO, the United Nations Children's Fund (UNICEF), the United Nations Development Program (UNDP), the United Nations Population Fund (UNFPA), the Nigerian Federal Ministry of Women's Affairs and the Nigerian Federal Health Ministry. The study covered 148,000 women and girls from 31 community samples nationwide.

The results from fragmented data, according to IAC/Nigeria, show the following prevalence and type in the following states in Nigeria. Abia (no study); Adamawa (60-70 percent, Type IV); Akwa Ibom (65-75 percent, Type II); Anambra (40-60 percent, Type II); Bauchi (50-60 percent, Type IV); Benue (90-100 percent, Type II); Borno (10-90 percent, Types I, III and IV); Cross River (no study); Delta (80-90 percent, Type II); Edo (30-40 percent, Type II); Enugu (no study); Imo (40-50 percent, Type II); Jigawa (60-70 percent, Type IV); Kaduna (50-70 percent, Type IV); Katsina (no study); Kano (no study); Kebbi (90-100 percent, Type IV); Kogi (one percent, Type IV); Kwara (60-70 percent, Types I and II); Lagos (20-30 percent, Type I); Niger (no study); Ogun (35-45 percent, Types I and II); Ondo (90-98 percent, Type II); Osun (80-90 percent, Type I); Oyo (60-70 percent, Type I); Plateau (30-90 percent, Types I and IV); Rivers (60-70 percent, Types I and II); Sokoto (no study); Taraba (no study); Yobe (0-1 percent, Type IV); Fct Abuja (no study).

While all three forms occur throughout the country, Type III, the most severe form, has a higher incidence in the northern states. Type II and Type I are more predominant in the south. Of the six largest ethnic groups, the Yoruba, Hausa, Fulani, Ibo, Ijaw and Kanuri, only the Fulani do not practice any form. The Yoruba practice mainly Type II and Type I. The Hausa and Kanuri practice Type III. The Ibo and Ijaw, depending upon the local community, practice any one of the three forms.

ATTITUDES AND BELIEFS:

The Women's Centre for Peace and Development (WOPED) has concluded that Nigerians continue this practice out of adherence to a cultural dictate that uncircumcised women are promiscuous, unclean, unmarriageable, physically undesirable and/or potential health risks to themselves and their children, especially during childbirth. One traditional belief is that if a male child's head touches the clitoris during childbirth, the child will die.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are

generally bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

TYPE IV:

Type IV includes the introduction of corrosive substances into the vagina. This form is practiced to a much lesser extent than the other forms in Nigeria.

These procedures can take place anytime from a few days after birth to a few days after death. In Edo State, for example, the procedure is performed within a few days after birth. In some very traditional communities, if a deceased woman is discovered to have never had the procedure, it may be performed on her before burial. In some communities it is performed on pregnant women during the birthing process and accounts for much of the high morbidity and mortality rates. It varies among ethnic groups.

Highly respected women in the community, including traditional birth attendants (TBAs), local barbers and medical doctors and health workers usually perform the procedure. Unless performed in medical facilities, it is generally performed without the use of anesthesia.

OUTREACH:

Much is being done to combat this practice. The campaign against FGM/FGC has long been waged, for the most part, by international, national and non-governmental organizations. IAC/Nigeria holds meetings and programs in both urban and rural communities throughout the country to inform the public about this subject. It uses videos, booklets and the mass media to reach school age children.

In 1997, outreach programs on the dangers of this practice were intensified. In the states of Osun and Bayelsa, nurses and midwives were trained about the harmful health effects and how to select, train and supervise TBAs. There was extensive community outreach to men, women, school children and health workers. Anatomical models, films and posters were used. Posters were distributed in villages.

Also actively campaigning against this practice are the National Association of Nigerian Nurses and Midwives, the Nigerian Medical Women's Association and the Nigerian Medical Association. These three groups in particular are against the legitimization of this practice as a medical necessity for females and are working to inform all Nigerian health practitioners about the harmful effects of the practice. The National Association of Nigerian Nurses and Midwives created a national information package about the harmful effects of the various procedures.

WHO, UNDP, DFID of Great Britain and Daneco of Sweden are actively funding Nigerian NGOs in addressing this practice. International organizations have adopted plans of action to eradicate these practices in Nigeria. WHO has a three-year short-term plan (1996-1998); an eight-year medium-term plan (1999-2006); and a nine-year long-term plan to eventually eliminate this practice from Nigeria and the rest of Africa.

Nurses and pediatricians have long campaigned against this practice. They have campaigned nationwide starting with national workshops in Lagos. Trainers were trained who in turn conducted informational activities about this practice at the state and local community levels. A variety of methods were used to get the message across as to the harmful effects. These included dramas, community mobilizations, national television talk shows, radio broadcasts, articles in newspapers, etc. The once taboo subject is now discussed in the open.

The government has publicly opposed this practice. Government officials have voiced their support for the campaign against FGM/FGC. Both the Federal Health Ministry and the Federal Ministry of Women's Affairs support the nationwide study on this issue.

In conjunction with a number of House State Assembly members, medical workers, attorneys and NGO representatives, WOPED organized a national policy symposium on FGM/FGC in May 2000. The symposium revealed that over the past decade both government ministries and NGOs have been active and mutually collaborative in studying how to end this practice. However, little has been accomplished beyond the recommendation stage.

Nigeria was one of five countries that sponsored a resolution at the forty-sixth World Health Assembly calling for eradication of harmful traditional practices, including FGM/FGC.

Most NGOs working on this issue claim that helping traditional communities change their cultural folklore is necessary to end this practice. Proverbs, songs, theatrical and dance performances and other cultural activities have reinforced this practice for centuries. The NGOs also point out that efforts to end the practice will fail unless Nigerian men learn that uncircumcised women are marriageable, will not be promiscuous and are not poor risks as mothers.

DFID of Great Britain is working with IAC/Nigeria on a pilot project with ten excisors. The excisors were educated about the criminalization of FGM/FGC in their state. DFID then purchased deep freezers and ice cream makers for each excisor to start her own business in her community. In each case, the excisor has been earning enough to replace her former practice of FGM/FGC as her source of income. When families have brought their daughters to them to be circumcised, they are refusing to refer them to others still practicing and have even threatened to bring in the authorities if the families try to pursue the operation.

The United States Agency for International Development (USAID) is working with members of the Women's Caucus of the National Assembly in addressing women's health issues, including this problem. The Calvary Foundation based in Enugu State was awarded a grant of US\$20,000 from the U.S. Embassy's Democracy and Human Rights Fund to continue its campaign to ban this practice in five southeastern states.

LEGAL STATUS:

There is no federal laws banning FGM/FGC in Nigeria. Opponents of this practice rely on Section 34(1)(a) of the 1999 Constitution of the Federal Republic of Nigeria that states, "no person shall be subjected to torture or inhuman or degrading treatment," as the basis for banning the practice nationwide.

A member of the House of Representatives has drafted a bill, not yet in committee, banning this practice.

Edo State banned this practice in October 1999. Persons convicted under the law are subject to a 1000 Naira (US\$10) fine and imprisonment of six months. While opponents of the practice applaud laws like this one as a step in the right direction, they have criticized the small fine and lack of enforcement thus far.

Ogun, Cross River, Osun, Rivers and Bayelsa states have also banned the practice since 1999.

Most anti-FGM/FGC groups are focusing their energies at the state and local government levels. IAC/Nigeria is pursuing a state by state strategy to criminalize the practice in all 36 states. It first meets with the local government area Chairman about the harmful health effects of the practice. The Chairman is relied on to make contact with Council members, traditional rulers and other opinion leaders to discuss the problems associated with this practice and to work on alternative rites to satisfy cultural concerns. Only after consensus has been reached at this level, are all employed in the statewide campaign to ban the practice. IAC/Nigeria expects the campaign to take at least five years to reach all 36 states.

PROTECTION:

We are unaware of any support groups to protect an unwilling woman or girl against this practice.

**FEMALE GENITAL MUTILATION (FGM)
or
FEMALE GENITAL CUTTING (FGC) IN SENEGAL**

PRACTICE:

Type II (commonly referred to as excision) and Type III (commonly referred to as infibulation) are both practiced in Senegal. Type II is the most common form of female genital mutilation (FGM) or female genital cutting (FGC). Certain minority groups practice Type II and Type III. They are most common among Muslim groups in the eastern part of the country. Most Senegalese women, however, have not undergone either procedure. It is growing less common due to urbanization and education.

INCIDENCE:

A study into the incidence of Type II and Type III in Senegal was undertaken in 1988 by the Environmental Development Action in the Third World (ENDA). The study showed that approximately 20 percent of the female population had undergone one of these procedures. Other estimates place this figure between 5 and 20 percent. The Wolof ethnic group that makes up 43 percent of the population, the Serere ethnic group that makes up 15 percent of the population and most Christians, regardless of their ethnic group, do not practice either form. It is hardly practiced at all in the most heavily populated urban areas.

It is estimated that up to 88 percent of females among the minority Halpularen (Peul and Toucouleur) in rural areas of eastern and southern Senegal practice one of these forms. However, the practice is less common among urban Halpularen. Estimates put the urban Halpularen rate at 20 percent. Mostly rural elements of the Diola and Mandingo minority ethnic groups practice it as a puberty initiation rite. The Sarakole, Bambara, Mande and Tenda ethnic groups also practice it.

ATTITUDES AND BELIEFS:

The minority groups that practice Type II or Type III believe that the Quran requires this. Some Muslim leaders are beginning to preach that Islam does not require women to undergo either of these procedures.

TYPE II:

Type II is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are

generally bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

Ninety percent of the females who undergo one of these procedures are between two and five years of age. The age when the procedure takes place differs with the ethnic group. It is generally performed by women of the blacksmith's caste who are said to be gifted with knowledge of the occult, without the use of anesthesia. It is carried out sometimes as part of a puberty initiation rite.

OUTREACH ACTIVITIES:

In February 1998, former President Diouf called for the eradication of this practice and a national debate on the subject. The Ministry of Women, Children and the Family sponsors public programs on this subject. An information campaign has been carried out on the radio. A popular song was written about the practice. Seminars have been organized about the religious and health aspects. In 1993, ENDA organized a workshop for traditional birth attendants (TBAs) and excisors on the harmful health aspects of the practice.

CAMS (Campaign pour L'abolition des Mutilations Sexuelles) has been working in Senegal since 1982 to eradicate this practice. It organizes seminars and set up a gender research unit on women at the University of Dakar. The Women's Association Diourbel organizes meetings to raise awareness and provide information and instruction about the practice. The Women's Association for Strengthening the Struggle against Traditional Practices was set up in 1986. Workshops are held to raise awareness and provide information to the population about the harmful effects of the practice. Men are also the focus of this effort.

Following the accession to power of President Abdoulaye Wade in March 2000, the new Minister of the Family and National Solidarity spearheaded a new study of the practice in Senegal. The goals of the study include developing an integrated governmental approach to the fight against the practice; identifying those scattered groups working against the practice and their methods; tracking and assessing the situation of those women who have publicly abandoned the practice; reviewing the current extent of the practice and assessing the impact of Senegal's 1999 law.

In 1999, the U.S. Embassy's Democracy and Human Rights Fund (DHRF) program gave a grant of US\$19,000 to the non-governmental organization (NGO) ENDA-GRAF in support of increasing public awareness with regard to this practice. The funds were used for theater productions in the Kolda, Thies, Rufisque and Dakar regions; for seminars and discussion groups; and for radio programs on this topic.

The National Committee of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) works to provide information at the grass roots level about the harmful health effects of the practice. Panel discussions and seminars are held. In 1997, seminars were held with excisors in Tamba, Kolda and Dakar.

Strategies for addressing this issue in Senegal include distribution of information about the harmful effects of the practice; involvement of a wide range of interested groups such as schools, the Red Cross and scouts; provision of informational materials on the practice; use of the radio, theater and films to get the word out and medical research.

In 1991, the NGO Tostan (which means *breakthrough* in the Wolof language) began a non-formal education program for women in more than 450 villages. The program has been supported financially by the United Nations Children's Fund (UNICEF), the government of Senegal and the American Jewish World Service.

It emphasizes participation and empowerment of women and uses materials that draw on Senegalese culture and oral traditions. Instructional materials include games, small group discussions, theater, songs, dance, story telling and flip charts. Recognizing that women have other responsibilities in raising their families, the classes meet several times a week for two to three hours at a time. The drop

out rate is almost nil. Classes are held in a number of villages, including villages whose residents frequently inter-marry. Modules for learning address such issues as literacy skills, problem solving, women's health and hygiene, management skills, leadership skills, negotiating skills and human rights. They are given in four local languages, Wolof, Senere, Mandinka and Pulaar. This program is currently being replicated in Sudan, Mali and Burkina Faso.

A shortened version called the Village Empowerment Program, which uses those skills determined to be most important in the abandonment of FGM, problem solving, hygiene, women's health and human rights, is being implemented in a number of villages involving the entire village, both men and women.

At the outset, Tostan did not state whether FGM/FGC was right or wrong. It was the women themselves who, after taking the program, decided that they no longer wanted their daughters to be subjected to this practice. Using the skills learned in the program, they approached their husbands and village leaders to engage the entire community to stop the practice.

On July 31, 1997, the village of Malicounda Bambara (population 3000) decided to abandon the practice. Many women of the village, inspired by their skills training classes from Tostan, took the initiative to inform other women, men and children of the village about the harmful health effects of the practice and the need to abolish it. The decision followed a period of seven to eight months during which no case of FGM/FGC was reported in the village.

The Imam of the mosque endorsed the villagers' decision, noting that the practice had originally sought to protect a girl's virginity until marriage. According to the Imam, the context has changed because even though excised, many girls lose their virginity before marriage and the practice scars girls and exposes them to health risks including tetanus and AIDS.

The women from Malicounda traveled to Ngerin Bambara and Ker Simbara to tell the women in those villages who had taken the same Tostan course, about their decision to abandon the practice. The village of Ngerin Bambara publicly declared the abandonment of this practice on November 6, 1997.

Two Bambara men, one an Imam from Ker Simbara, then walked from village to village convincing members of their extended families to stop this practice. Their efforts led to the *Diabougou Declaration* in which 50 representatives of 8,000 villagers from 13 communities in the regions of Thies and Fatick publicly decided in a joint declaration to abandon the practice. They declared their commitment to end this practice and spread this knowledge and decision to communities still engaged in the practice. One Imam said that Islam in no way obligates women to undergo any of these procedures.

Tostan's work has expanded over the years and as of November 2000, a total of 174 villages throughout Senegal had publicly abandoned the practice.

On November 4, 2000, several villages in the departments of Podor and Matam made public pledges that generated a level of controversy not hitherto encountered by Tostan. This region of the Fouta, home to the minority Halpularen who practice FGM/FGC extensively, is characterized by Tostan as the most 'difficult' region of Senegal to work in. Although the November 4 Fouta pledges made no specific mention of FGM/FGC and instead simply committed to taking "all necessary measures to protect the health and rights of our girls and our women," the pledging ceremony was attended by pro-FGM/FGC religious leaders and villagers. The opposition encountered angered and energized women in the Tostan program from neighboring villages who had not yet made public declarations.

The latest abandonment of the practice took place the region of Kolda. On March 25, 2001, the 108 villages of the rural community of Mampatim in the region of Kolda organized a public declaration to abandon FGM/FGC, stop early marriages and promote family planning. This represents approximately 10,000 girls who will not be cut over the next few years. This abandonment resulted from the Tostan basic education program implemented in 40 of the villages of the Mampatim rural community, as well as social mobilization activities carried out by the recently educated villagers themselves.

LEGAL STATUS:

A law that was passed in January 1999 makes FGM/FGC illegal in Senegal. President Diouf had earlier appealed for an end to this practice and for legislation outlawing it. The law modifies the Penal Code to make this practice a criminal act, punishable by a sentence of one to five years in prison. A spokesperson for the human rights group RADDHO (The African Assembly for the Defense of Human Rights), noted in the local press that "Adopting the law is not the end, as it will still need to be effectively enforced for women to benefit from it."

The period since passage of the law in January 1999 has seen no convictions. In July 1999, the public prosecutor in Tambacounda ordered the arrest of the grandmother and mother of a five year old girl, following a complaint filed by the girl's father alleging the two women had ordered FGM/FGC performed on his daughter. The practitioner was also charged. Following emotional public outcry in the region, however, the cases were not pursued and no convictions resulted.

Although the 1999 law has supporters among many women and among NGOs pursuing the elimination of this practice, opposition to the law has not come from FGM/FGC supporters alone. Representatives of Tostan, which follows a basic education and empowerment approach, maintain that the law has made their work that much more difficult since it has increased defensiveness among the populations practicing it.

The press has suggested that the passage of the law has driven the practice underground.

PROTECTION:

Although the government has been actively seeking to eradicate this practice, we are unaware of any protection in place that might help a woman who wished to avoid it. Since most women undergo this practice between the ages of two months and six years, cases of FGM/FGC candidates themselves seeking protection from the practice are non-existent.

Prepared by the Office of the Senior Coordinator for International Women's Issues, Office of the Under Secretary for Global Affairs, U.S. Department of State, June 2001

FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN SIERRA LEONE

PRACTICE:

Type II (commonly referred to as excision) is the form of female genital mutilation (FGM) or female genital cutting (FGC) widely practiced on women and girls in Sierra Leone. It is generally practiced by all classes, including the educated elite. Sierra Leoneans who live abroad sometimes bring their daughters back to Sierra Leone to participate in initiation rites that include this procedure. Type II is usually carried out within a ritual context. It is part of the passage from childhood to womanhood.

INCIDENCE:

Some estimates place the percentage of women and girls in Sierra Leone who undergo this procedure at 80 percent. Others put the percentage higher at 90 percent. All ethnic groups practice it except Krios who are located primarily in the western region and in the capital, Freetown.

ATTITUDES AND BELIEFS:

The customary power bases of women in Sierra Leone lie in the secret societies. Women who administer puberty rites are revered, feared and believed to hold supernatural powers. Membership in these secret societies, including *Sande* and *Bundo*, lasts a lifetime.

Groups of girls of approximately the same age are initiated into these societies. Part of the ritual is the cutting. Girls initiated together form a bond and this sisterhood lasts throughout their lives. The girls take an oath that they will not reveal anything that happened during the puberty rite.

It is believed that once initiated into the society, the girl has passed into womanhood. She now has adult status and can participate in society as a woman. The secret societies are supported by some members of the influential elite who are also members of the societies or have relatives who are.

Non-members of the secret societies are considered to be children, and not accepted as adults by society. They are generally barred from taking up leadership positions in Sierra Leone society. Children who come of age and have not gone through the puberty rite are liable to be forcibly seized to undergo the procedure.

In working with ex-child combatants, it was found that a number of the female ex-combatants sought membership in the secret societies as a form of self-protection and evidence that they were reintegrating into society.

TYPE II:

Type II is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

Traditional excisors earn income and in-kind remuneration for performing this procedure. It is generally performed without the use of anesthesia.

OUTREACH:

In Sierra Leone, there is a National Committee of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), the Sierra Leone Association on Women's Welfare (SLAWW). It was set up in 1984 and advocates informing the public about the dangers of FGM/FGC and for legislation to eradicate the practice. Jurists have been brought in to participate in the campaign against this practice.

The approach by SLAWW has been very cautious. It has initiated informational activities about the practice. There is now discussion of the practice and its problems within educated circles among doctors, midwives, nurses, teachers, students and journalists.

SLAWW has established an alternative employment opportunity project for excisors. Programs on the health problems associated with the practice for excisors have also been held.

The activities of SLAWW were interrupted in May 1997 due to the political crisis. Most of its members had to flee the country. However, it continued its advocacy work with members of other non-governmental organizations (NGOs) such as Marie Stoope, the YWCA, the Methodist Ministers Wives' Association, the Council of Churches of Sierra Leone and the Young Muslim Brotherhood. These organizations often invite SLAWW to give talks on harmful traditional practices, particularly FGM/FGC,

childhood marriage and pregnancy. At each talk the SLAWW publicity secretary makes certain the talk is in the news in all the different local languages.

SLAWW took part in the March 8, 1998 International Women's Day celebration and handed out material on the adverse effects of traditional practices. Included were pamphlets, badges, posters, T-shirts and other printed material. Many of the literate adolescents who took the materials to read promised to act as agents of change in their homes, schools and communities. The slogan on the materials read: "*SLAWW (IAC National Committee) abhors Harmful Practices but encourages Good Ones.*"

In early 1999, their activities were again interrupted by the invasion of Freetown.

A private grassroots program includes teaching about the dangers of FGM/FGC and ways to eradicate it. Seminars are held with primary and secondary school teachers on the dangers of the practice. The program also assists girls who interrupt their education because of pregnancy. The Kenema Voluntary Health Workers Association has also organized meetings for regional leaders on FGM/FGC.

The National Drama Group performed a play in the latter part of 2000 that presented a message of a girl being able to make her own choice with respect to excision. The play was attended by the President and other senior ministers and received reasonable press coverage.

LEGAL STATUS:

There is no law prohibiting FGM/FGC in Sierra Leone.

PROTECTION:

Despite the fact that there are no laws prohibiting this practice in Sierra Leone there was a 1996 case of a 28-year old woman forcibly abducted by the Bundo Society in Freetown and subjected to the procedure. The woman brought criminal charges against the society. The outcome of this case is unknown.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN SOMALIA

PRACTICE:

The most common form of female genital mutilation (FGM) or female genital cutting (FGC) practiced in Somalia is Type III (commonly referred to as infibulation and in Somalia, the "Pharaonic circumcision"). Eighty percent of all genital procedures for women and girls consist of this form which is the most harmful form. The less radical or Type I (commonly referred to as clitoridectomy and in Somalia sometimes called "sunna") is practiced mainly in the coastal towns of Mogadishu, Brava, Merca and Kismayu. The procedures leave a lifetime of physical suffering for the women.

INCIDENCE:

Virtually all Somali women are subjected to one of these procedures. A recent estimate by the United Nations Children's Fund (UNICEF) places the percentage of the women in Somalia who have undergone this procedure at 90 percent. Earlier estimates had placed the percentage at 96-98 percent. A 1983 national survey by the Ministry of Health found a prevalence of 96 percent. In October 1999, CARE International carried out a safe motherhood survey in Somaliland (northwest Somalia) to determine, among other things, the prevalence of FGM/FGC. It found the practice to be universal in this area of Somalia among the women sampled, with 91 percent undergoing Type III and nine percent Type I. These suggest that it is well established in all areas of the country and in most, if not all, the ethnic groups. It is commonly performed on girls as young as six or seven years of age.

ATTITUDES AND BELIEFS:

Many Somalis mistakenly view this procedure as a religious obligation. The concept of family honor is also involved. It is carried out to ensure virginity. Because virginity of daughters and family honor are related, it is believed that the family's honor will also remain intact if the daughters are subjected to this procedure. Women who have not undergone this procedure may be thought of as having loose morals. A girl who has not undergone it will result in less bridewealth for her father and brothers.

There are several other rationales expressed for the practice in Somalia. Some men claim the artificial tightness heightens sexual enjoyment. Some say the smoothness of the scar is esthetically beautiful.

The CARE study showed a difference in attitude toward this practice between rural and urban women. A higher number of urban women than rural women, felt there was nothing good about the practice. Forty percent of all women interviewed felt there was nothing bad about the practice. Eleven percent of those interviewed did not want their daughters to undergo this procedure.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris. This is the mildest form.

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are generally bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

In the cities, these procedures generally take place in a medical facility under anesthesia. If the operation is performed in a rural village, an old woman excisor performs the procedure without anesthesia. The excisors in Somalia, unlike in some other African countries, are not highly respected. They do not wield influence or have much status within the traditional power structure.

OUTREACH ACTIVITIES:

Despite the fact that the practice is so entrenched in Somali culture and custom, women began working to eradicate the practice as early as 1977. In that year, the Somali Women's Democratic Organization (SWDO) was formed. It became the implementing agency appointed by the now collapsed government of Siad Barre for the abolition of this practice.

To eradicate the dangers and damage caused by this procedure as performed by traditional excisors, the procedure was encouraged to be carried out in a hospital. The government supported an alternative method, which was to prick the clitoris to obtain a drop of blood. It was hoped that this method would eventually replace the more dangerous Type III. However, this strategy did not work as had been hoped and the practice was eventually banned in all government hospitals.

In 1988, the government launched a campaign to eradicate the practice completely on health and religious grounds. The campaign maintained the operation was dangerous to women's health and not called for in the Quran. It was even pointed out that it would not guarantee virginity.

A center was set up in the Somalia Academy of Arts and Sciences in the early 1980s to conduct studies on this practice. A Swedish Agency, SAREC, funded this. The center carried out research into the physical, psychological and sociological aspects of the practice.

The Institute of Women's Education (IWE) was set up in 1984 by the Department of Non-Formal Education of the Ministry of Education. The Institute focused on improving women's living conditions by improving their income, health and nutrition. It focused on improving female literacy and organizing women's groups among female community leaders. The latter were to encourage activities for rural development that included participation of women.

The IWE commenced activities in the mid-1980s against the practice of FGM/FGC. This was included entirely in a general health program called the Family Planning Project. These activities were not very successful, however, because they did not receive money from the government and the government had not passed any legislation outlawing this practice.

In 1987, SWDO and the Italian Association for Women and Development (AIDOS) founded an eradication project in Somalia. AIDOS provided technical and methodological support and SWDO was responsible for the content and direction of the project. SWDO approached the practice as a health issue. It feared an approach based on female rights (such as that of sexual freedom) would surely fail.

SWDO organized a campaign that produced information packets including audio-visuals for women, young people, religious leaders and medical personnel in the local language. It also provided workshops for trainers and held seminars for women and even organized a poetry contest on why the practice was dangerous to women and girls. An international conference was held in Mogadishu in 1989 on "Female Circumcision: Strategies to Bring about Change." The Somali Revolutionary Party, which was in power at that time, gave moral support to the project.

However, once Siad Barre's Somali Revolutionary Party was overthrown and the country thrown into turmoil in 1991, the technical basis for the campaign was destroyed.

Some international agencies have recently begun anti-FGM/FGC educational campaigns. These campaigns have attempted to enlist women and religious leaders in the fight against the practice. Religious leaders have, in some instances, been persuaded to tell their adherents this practice is a cultural, not a religious practice.

Since 1996, UNICEF in Somalia has supported a series of awareness raising seminars attended by women's grassroots organizations, religious leaders, politicians, health professionals and other representatives of the population. In 1997, the Government of Somaliland, in collaboration with UNICEF and other agencies, organized a National Seminar on FGM/FGC. The outcome was to establish an intersectoral committee at a national level and a regional task force to develop policies on eradication of this practice.

UNICEF sponsored workshops in Mogadishu, Galgaddud and Mudug regions in 1999-2000. At a workshop held in Hargeisa on April 18-19, 2000, the participants developed a Somaliland Declaration calling on the Government and the people of Somaliland to eradicate this practice in the country. In collaboration with Al Azhar University, Cairo, UNICEF organized an FGM/FGC study tour for seven sheiks

and two national officers from September 20-October, 2000. UNICEF was then to begin a "training the trainers: anti-FGM/FGC program."

In 2000, the U.S. Embassy provided funds through its Democracy and Human Rights Fund (DHRF) to the Voice of Midwives Association for a campaign to raise public awareness of the harmful effects of this practice. A grant of US\$10,173 was provided for meetings and discussions throughout Somaliland, incorporating the use of drama and other traditional techniques. In 1998, the Embassy provided US\$20,000 from DHRF to UNICEF to assist its project of building consensus against FGM/FGC in four communities in Somaliland.

LEGAL STATUS:

Although the former government's policy on this practice was for its complete eradication, this policy was never translated into law. There is no national law specifically prohibiting FGM in Somalia. There are provisions of the Penal Code of the former government covering "hurt", "grievous hurt" and "very grievous hurt" however, which might apply.

In November 1999, the Parliament of the Puntland administration unanimously approved legislation making the practice illegal. There is no evidence, however, that this law is being enforced.

PROTECTION:

Prior to the country's relatively recent upheaval, there appeared to be a good beginning at creating some type of relief from this practice with a number of outreach organizations in existence. The work of these organizations, however, was disrupted during the fighting.

There is also no national judicial system or central authority. Some regions have established local courts rendering judgments based on traditional and customary law, Islamic Shari'a law, the Penal Code of the defunct Siad Barre government or some combination of the three. It is unlikely such a system would uphold any anti-FGM/FGC relief given the strong foundation it enjoys in traditional society.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN SUDAN

PRACTICE:

Type I (commonly referred to as clitoridectomy and referred to as "sunna" in Sudan), Type II (commonly referred to as excision) and Type III (commonly referred to as infibulation) are the forms of female genital mutilation (FGM) or female genital cutting (FGC) widely practiced in the northern part of Sudan. Type III is the most common form. FGM/FGC crosses religious and ethnic lines. It is practiced by both Muslim and Christian women.

INCIDENCE:

A 1991 Demographic and Health Survey of 5,860 women in northern Sudan, found that 89 percent practice one of these forms. Eighty-seven percent of urban women and ninety-one percent of rural women practice it according to a survey conducted from 1996 to April 2000 by the Sudan National Committee on Traditional Practices (SNCTP) and Save the Children Sweden. A United Nations publication, "The Progress of Nations", also estimates that 89 percent of northern Sudanese women and girls, nearly 10 million, have been subjected to one of these forms.

A study conducted by SNCTP and Save the Children Sweden sampled secondary school students and their mothers. It found that in urban areas 87.6 percent of the female students and 89.5 percent of the mothers sampled had been circumcised. In rural areas, 90.8 percent of the female students and 91.3 percent of the mothers had been circumcised.

Among mothers studied, 15.2 percent had undergone the milder form of "sunna" or Type I and 84.8 percent Type III. Only 50 percent of university graduate mothers had undergone any form.

All three forms are practiced in the northern part of the country. A very high prevalence, predominantly Type III that is the most harmful, is found throughout most of the northern, northeastern and northwestern regions. It is not practiced in the south, although some southern women who are married to northern men and live in the north part of the country, elect to undergo the procedure. It has never been part of traditions in the south.

Many educated urban families do not subject their daughters to this practice. Those who do not are increasing. Many other families are abandoning the severe form for the less radical methods. According to a 1983 study, over 80 percent of the procedures performed were Type III. According to the recent SNCTP study, for women born after 1980 who were subjected to this practice, 57 percent were infibulated while nearly 43 percent were subjected to the milder "sunna." There is believed to be a slight decrease in these practices in recent years.

ATTITUDES AND BELIEFS:

Reasons given for the practice include the belief that it will protect the girl's virginity. The external female genitals are considered unclean. The aim of the procedure is to produce a smooth skin surface and women who support the practice insist that it makes them cleaner. Clerics in Sudan do not support Type III, the most severe form. Some of them, however, condone the less radical forms of the practice but do not insist on it.

In northern Sudan an elaborate ceremony generally surrounds the procedure. This is usually for girls (infants to 11 years old). The celebrations are the same for all. A young woman subjected to this procedure emerges marriageable while a younger girl receives gifts of special food and clothes. The ceremonial aspect is disappearing in most groups.

TYPE I:

Type I is the excision (removal) of the clitoral hood with or without removal of all or part of the clitoris.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are

generally bound together from the hip to the ankle so she remains immobile for approximately 40 days (depending on who performed the procedure) to allow for the formation of scar tissue.

These procedures are generally carried out in private clinics, by midwives in the villages and by so called "health visitors" whose main job is to make house to house visits to disseminate information on hygiene and promote a healthy environment. The procedure is often carried out without the use of anesthesia.

OUTREACH ACTIVITIES:

Attempts have been made to eradicate FGM/FGC for the past 50 years. Despite this, women are still being infibulated today. With the weight of the present government behind it, an intensive campaign against the practice has been launched. Religious groups, the media and women's organizations have joined forces to eradicate this damaging practice. The government has made limited efforts to educate health personnel on this issue and to introduce information about this practice into the school curricula.

A number of organizations have tried to protect women and fight against this practice. They are SNCTP, the Organization for Eradication of Traditional Harmful Practices Affecting the Health of Women and Children (ETHP), the Mutawinat Group and the Babiker Badri Organization. The Ministry of Social Planning recognizes all groups and allows them to operate freely. They work closely with the United Nations Population Fund (UNFPA) under the Project for Information, Education and Communication and the United Nations Children's Fund (UNICEF).

SNCTP, funded primarily by the government of the Netherlands, has as a primary goal the elimination of this practice. It produces educational materials, trains advocates and puts on public awareness seminars to accomplish this.

ETHP was established in 1984 by a resolution signed by the Minister of the Interior and Social Welfare. It succeeded the Sudanese National Committee for the Eradication of Female Circumcision (SNCEFC) which was founded in 1981 by a decree of the Minister of the Interior and Social Welfare.

The objective of ETHP is the eradication of the practice by focusing on instruction and information for key groups. Workshops, seminars, courses and discussions have been held. Local midwives have been given formal training. In 1997, public health sessions were held in rural areas of Khartoum, Nile River, Northern, Sinnar and White Nile states. Informational materials were distributed. Research on the psychosocial aspects of the practice and attitude change was implemented during 1997. This involved health visitors, village midwives and traditional birth attendants (TBAs) from both urban and rural areas and from different religious and cultural backgrounds.

The Babiker Badri Organization has also developed teaching methods for women and children, special games, a question and answer booklet, posters, etc. The aim is total eradication.

The Mutawinat Group, established in 1990, held a workshop in 1997 that brought together governmental and non-governmental organizations. They are pursuing an innovative study that documents the status of women who have not undergone this procedure and are working to get information about the practice into school curricula.

Members of the medical profession are starting to involve themselves in the issue. People are discussing the issue openly. While few have abandoned the practice altogether, many have opted for the milder "sunna" procedure.

Eradication of Type III or infibulation was integrated into the curriculum for community health nurses at the Khartoum Nursing College. It is hoped this approach can also be included in curricula for medical students and student midwives. Eradication of this and other harmful traditional practices is also to be included in nutritional teachers' national education programs.

LEGAL STATUS:

The government of Sudan publicly opposes Type III or infibulation. Although today there is no law against FGM/FGC, Sudan is the first country in Africa to have a record of legislating against it. As early as 1930 an article appeared, written by a medical student, about the harmful effects of the practice and urging that it be abolished. Sudan was then under an Anglo-Egyptian administration. The article was withheld from distribution by government authorities.

In 1943, a medical committee was set up by the governor-general to study the practice. The conclusion was that it was cruel and should be abolished. A radio and media campaign followed. Nothing, however, was done. As a result, an amendment to the 1925 Penal Code was introduced in 1946 to outlaw Type III. The 1946 Penal Code prohibited Type III, but permitted the less severe form. Families hurried to have their girls infibulated before the law went into effect. The law provided for imprisonment up to seven years and a fine for those who carried out the procedure. There were violent demonstrations after the first arrests.

The law was ratified again in 1956, after Sudan became independent. The Penal Code prohibited Type III but allowed the removal of the "free, projecting part of the clitoris". The punishment was now five years imprisonment and/or a fine if someone performed Type III.

"1. Whoever voluntarily causes hurt to the external genital organs of a woman is said, save as hereafter excepted, to commit unlawful circumcision. Exception: It is not an offense under this section merely to remove the free and projecting part of the clitoris.

2. Whoever commits unlawful circumcision shall be punished with imprisonment for a term which may extend to five years or with a fine, or both."

The law against Type III continued to exist in the Penal Code of 1974 but was dropped in the 1983 Penal Code. In 1991, the government affirmed its commitment to its eradication. It claimed it was against Islam and a crime punishable under the Penal Code. The 1991 Penal Code, however, does not mention any of these forms. There is currently no law that forbids this practice per se.

Other provisions of the Penal Code covering "injury" might potentially cover FGM/FGC. There are reports that some practitioners have been arrested but no further information is available. In 1992 a case involving FGM/FGC was brought under the general physical injury law. The outcome is unknown.

PROTECTION:

Despite a massive effort to eradicate the more severe form of FGM/FGC and a law that prohibited it, there has been little effort over the years to enforce it.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN TOGO

PRACTICE:

The form of female genital mutilation (FGM) or female genital cutting (FGC) practiced in Togo is Type II (commonly referred to as excision). It is practiced in four of Togo's five prefectures, with the highest incidence being in the prefecture of Sokode. It transcends religious and ethnic groups. It occurs among Christians, Muslims and Animists. Most of the groups practicing it in Togo happen to be Muslim. It is not, however, based on religious tenets.

INCIDENCE:

The U.S. Embassy's Democracy and Human Rights Fund (DHRF) provided funds for a research project on FGM/FGC in Togo that was carried out in 1996 by the Demographic Research Unit, a statistical research branch of Togo's University of Benin. The project was a two-pronged study. First, accurate statistics were gathered on how many women and girls had undergone this procedure and the incidence by ethnic group and region. Second, a qualitative study, using interviews and focus groups, was carried out to examine the beliefs underlying the practice and the opinions of excised and non-excised women and men on the practice. The quantitative study covered the entire country and the qualitative study was necessarily concentrated in areas where Type II is currently practiced.

The study found that 12 percent, or one Togolese female in eight, has undergone this procedure. Two of Togo's largest ethnic groups, the Adja-Ewe and Akposso-Akebou, do not practice it. It tends to be limited to certain ethnic groups, among them the Cotocoli, Tchamba, Peul, Mossi, Yanga, Moba, Gourma and Ana-lfe. The Cotocoli, Tchamba, Mossi, Yanga and Peul recorded the highest incidence, ranging from 85-98 percent. Among several of the groups with a lower incidence, notably the Moba and Gourma (incidence of 22 percent and 12 percent respectively), close association with Peul populations has led to the adoption of this practice.

In demographic terms, women over 40 are more likely to have been excised than younger women. Educational level also makes a difference, with an incidence of 15.7 percent among the women with no education; 6.1 percent among those with primary education; and 4 percent for those with secondary or higher education. Broken down by religion, the figures are 63.9 percent for Muslims; 3.2 percent for Christians; 6.1 percent for Animists; and 10 percent for those claiming "other" religions.

Public awareness of the dangers of this practice is much higher in urban areas than in the more remote rural regions. Excisors usually go to remote villages to perform this procedure. Families are reported to come across the border from neighboring Burkina Faso (where laws outlawing this practice reportedly are more strictly enforced) to have the procedure performed in Dapaong, a community in the north of Togo.

ATTITUDES AND BELIEFS:

In this research project, 60 percent of the excised women interviewed were in favor of abolition of the practice. The women cited infection, hemorrhage and other health issues as particular problems for the excised. Thirty percent, however, felt that it remains an important cultural practice and would like it to continue. They intend to have their daughters excised.

The Demographic Research Unit, working with women's associations, local women's groups, health workers and others, organized eight focus group discussions on this practice in Togo. The groups covered younger women, older women, excised and non-excised, urban and rural women and two groups of men - one Muslim and the other predominately Christian. Focus group discussions were concentrated in regions and among ethnic groups where the practice occurs. Every group insisted that the practice was founded on traditions and was not called for in any religion practiced by these groups.

There are many customary beliefs surrounding this practice. One is that the person undergoing the procedure must be a virgin and that the blood of a non-virgin going through the procedure could blind the woman carrying out the procedure. Most participants in the group discussions felt that undergoing this procedure had little to do with any woman's subsequent sexual behavior. Whether she would be

virtuous or not or have a strong or weak sexual appetite depended more on the individual woman's character than whether she was excised or not.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

Type III or infibulation, the most harmful form, is not practiced in Togo. Type II typically takes place on girls older than six or seven years, except among the Peul, where infants are often excised. It could take place just before a woman is married.

It is often carried out as part of a "coming of age" ceremony and is accompanied by festivities and gifts when the girl or woman recovers (usually cited as one to two weeks). The parents pay for the procedure and festivities, unless the girl is already affianced, in which case the fiancée's family contributes to the cost.

In areas where it is practiced, an excised girl commands higher bridewealth than a non-excised girl. Depending on the region and the ethnic group, fees for performing the procedure range from US\$.40 to \$10. If the girl or woman is not a virgin, fees are adjusted upward and are accompanied by extra gifts such as chickens.

Women are the primary guardians of the puberty rite, which is tied closely to women's status and power. The procedure is normally carried out by women and is generally performed without anesthesia.

The Demographic Research Unit interviewed a number of excisors. Most claimed to use a razor blade for the procedure. Formerly a specially forged knife was used, but they said the knives are expensive and difficult to clean. Several commented that due to public health campaigns, they now use a different blade for each girl or woman.

Many admitted to having had health complications with some patients, but most denied that hemorrhage or infection was frequent or serious. One said that she had been dissuaded from further practice by a bad outcome for one of her patients. Most excisors claimed that problems were the result of "bad destiny", the fact that the girl was not a virgin or parents had not performed the appropriate ceremonies of propitiation.

OUTREACH ACTIVITIES:

The government has been very supportive of efforts to counteract this practice. It sponsors seminars and campaigns against this practice. As far back as 1984, a National Committee of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) was formed in Togo with the support of the Ministry of Social Affairs. This Committee, the Inter-African Committee for the Struggle Against Practices Harmful to the Health of Women and Children (CIAF), organized seminars and workshops for excisors, health workers, policy-makers and village women and men in the Tchaoudjo region.

In 1997, a major campaign was started in the Central Region in the regions of Tchamba and Tchaoudjo where the incidence of this practice is high. The campaign aims to inform all socio-professional groups, including political and administrative groups, traditional and religious authorities, students, etc. about the harmful effects. The U.S. Embassy provided grants from its Democracy and Human Rights Fund (DHRF) for some of their activities in 1997 and 1999.

CARE/Togo established a reproductive health care project that included FGM/FGC eradication in the Savanna (the northern most area of Togo). In May 1993, Togo sponsored the World Health Assembly resolution on harmful traditional practices. The World Health Organization (WHO) has taken the lead internationally in seeking a worldwide termination of the practice. In 1997, the German Volunteer

Service (DED) carried out a campaign in the Plateau Region where the practice is high. Twenty-five excisors were identified and they promised to stop their practice. DED agreed to finance a project of alternative income producing activities. Forty-five agents of change were also trained.

Human rights and women's rights groups in Togo have outreach programs to inform rural populations about their rights and the health dangers of this practice. According to a senior Togolese human rights activist, these outreach programs are having limited immediate success and it will take a generation before a significant reduction in this practice takes place. The YWCA also does extensive outreach.

The Togolese Association for the Well-Being of the Family (Association Togolaise pour le Bien-Etre Familial) organized an educational program in 1999 to raise public awareness of the recent law criminalizing this practice in Togo. The Group of Reflection and Action for Women in Democracy and Development (Groupe de Reflexion et d'Action Femme, Democratie et Developpement) is a women's activist group that works to protect women from this practice and to take care of the victims.

A documentary denouncing the practice of FGM/FGC has appeared on national (government controlled) television.

The U.S. Embassy has been active in promoting women's rights and informing the public about the dangers and consequences of this practice. DHRF-sponsored programs have been effective in providing information to rural populations about health problems related to this practice. These programs have received prominent and favorable coverage in government controlled print media. Other programs have supported the creation of illustrative booklets on the practice for women in rural areas and provided assistance to the Togolese League of Women's Rights to draft a law prohibiting FGM/FGC for presentation to the National Assembly.

In addition to the 1995 nationwide survey funded by the Embassy, it also funded an educational seminar about the practice of FGM/FGC in 1996 and an awareness program on this subject for over 30,000 Togolese in 1998. Participants in Embassy-funded seminars included religious and traditional leaders, students, government officials and excisors. In 1999, the DHRF provided funding for an educational program organized by CIAF/Togo. In October 2000, a Peace Corps volunteer conducted a four-day awareness program in Guerin-Kouka, an area where the practice is common.

LEGAL STATUS:

On October 30, 1998, the National Assembly unanimously voted to outlaw the practice of FGM/FGC. Penalties under the law can include a prison term of two months to ten years, depending on whether death occurred, and a fine of 100,000 CFA (US\$160) to one million CFA (US\$1,600). A person who had knowledge that the procedure was going to take place and failed to inform public authorities can be punished with one month to one year imprisonment or a fine of from 20,000 to 500,000 francs (approximately US\$32 to 800).

During deliberations on the law, legislators called for a widespread information campaign on the harmful health consequences of the practice. At least one excisor has been arrested under the law, but the outcome of the case is unknown.

Following passage of the law, the Ministry of Social Affairs and the Promotion of Women and the Ministry of Health, in collaboration with WHO and the United Nations Population Fund, organized a seminar on the enforcement of the law.

Several ministries followed this example with smaller campaigns to inform the public about the health problems associated with this practice. National radio and television, as well as private radio stations, have broadcast information about the legal and health consequences.

Togo's Constitution also incorporates in Article 50, the rights and responsibilities stated in the Universal Declaration of Human Rights. According to the Togolese Human Rights League, under Article 13 of the Constitution, women should be protected from involuntary submission to this procedure which provides the "...obligation of the State to guarantee each person's life, security and physical and mental integrity..." In addition, Article 21 provides that "...no one can be subjected to torture or other forms of cruel, inhumane or degrading punishment..."

Under customary practice, women become the property of the husband once a marriage takes place. Under Muslim tradition, however, a woman has the right to refuse marriage. It is not until after a marriage takes place that a husband can force his wife to undergo this procedure. A woman has the right to refuse. However, since she is considered the property of her husband she must submit to his will and he would be able to subject her to the procedure.

PROTECTION:

The NGO Group called Reflection and Action for Women in Democracy and Development works to protect women from this practice and take care of those who have already been subjected to it.

There is no documented precedent of women seeking protection from this practice in Togo. An official of the Ministry of Social Affairs has stated that the Ministry would seek to protect any woman who brought forward a claim of abuse of her human rights, including being subjected to this procedure.

A member of the Togolese Human Rights League says NGOs usually cannot do much to protect women because this is a family matter. If the family wanted it carried out, they could probably force it upon an unwilling woman. Now that there is a law against it, however, this should change.

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FEMALE GENITAL MUTILATION (FGM) or FEMALE GENITAL CUTTING (FGC) IN YEMEN

PRACTICE:

The most common form of female genital mutilation (FGM) or female genital cutting (FGC) practiced in Yemen is Type II (commonly referred to as excision). Type III (commonly referred to as infibulation) is practiced among the small East African immigrant/refugee community.

INCIDENCE:

According to the U.S. Agency for International Development (USAID) funded 1997 Yemen Demographic Mother and Child Health Survey, 23 percent of Yemeni women have undergone one of these procedures. In the sparsely populated Red Sea and Aden Coastal regions, this percentage rises to 69 percent, compared with 15 percent in the heavily populated highlands and 5 percent in the plateau and desert regions.

During the past two years, the Ministry of Public Health (MOPH) has conducted several studies on FGM/FGC with a focus on five Governorates - Sanaa City, Hodeidah, Hadramout, Aden and Al-Maharah. The studies included over 3000 men and women, including FGM/FGC practitioners and

clerics. The studies sought to determine the extent of the practice and to analyze its attitudinal and physiological aspects.

Findings of these studies revealed that over 96 percent of women in Hodeidah, Hadraumaut and Al-Maharah had undergone this procedure, while Aden and Sana'a city were 82 percent and 45.5 percent, respectively. Seventy percent of the procedures involved excision. The studies revealed that trained medical personnel performed only ten percent of the operations. Women who specialize in ear piercing, birth attendants, rayissas (women skilled in female circumcision) and relatives carry out most of the procedures.

According to the studies, the procedure is carried out 95 percent of the time in the home. Mothers are the primary decision-makers in determining if their daughters are to undergo this procedure.

The Demographic and Health Survey found that nearly all the procedures reported (97 percent) occurred during the first month of life. Health establishments housed only three percent of these, with 97 percent performed at home. A traditional birth attendant (TBA) or elderly female relative usually performs the procedure (68 percent and 19 percent respectively). Nurses, midwives and doctors perform seven percent of the procedures while barbers perform five percent of them. The usual tool is a razor blade, although scissors are used 20 percent of the time.

In Yemen, different religious sects hold different beliefs on whether or not a girl should undergo this procedure. The Shafi'i sect requires girls to be circumcised while the procedure is optional for those belonging to the Sunni sect.

ATTITUDES AND BELIEFS:

Nearly 48 percent of the Demographic Survey's respondents who know of this practice believed it should be discontinued. Eleven percent was unsure and the remainder was in favor of its continuation. Those who support the practice are confined to those who have undergone the procedure themselves.

Urban and educated women, despite a higher rate of circumcision among them, were less likely to support continuation of the practice. Most of those who support the practice cited cleanliness (46 percent of respondents in favor) as the reason for the practice. About one-third also cited either religious obligation or tradition.

Among the opponents of the practice, 68 percent oppose it because they consider it a bad tradition while one-third believe it to be anti-Islamic. Educated women were more likely to cite medical complications as a reason to discontinue the practice.

In the MOPH studies, of the 39 clerics who participated, 72 percent wanted the practice to continue for reasons of religious mandate, virginity and tradition. Those who opposed the practice said it was against women's dignity, not consistent with religious teachings and a generally bad habit. The men who participated in these studies were evenly split in the debate on whether the practice should continue.

The MOPH studies confirmed that the incidence of FGM/FGC is decreasing as women receive higher education. The daughters of 87 percent of the illiterate women had undergone this procedure while for daughters of university graduate mothers, this figure drops to 37 percent.

TYPE II:

Type II is the excision (removal) of the clitoris together with part or all of the labia minora (the inner vaginal lips).

TYPE III:

Type III is the excision (removal) of part or all of the external genitalia (clitoris, labia minora and labia majora) and stitching or narrowing of the vaginal opening, leaving a very small opening, about the size of a matchstick, to allow for the flow of urine and menstrual blood. The girl or woman's legs are generally bound together from the hip to the ankle so she remains immobile for approximately 40 days to allow for the formation of scar tissue.

OUTREACH ACTIVITIES:

Health officials, including the Minister of Public Health, and health care providers have publicly decried this practice. At a July 2, 2000 National Women's Committee (NWC) conference and at a lunch held July 11, 2000 to observe World Population Day, a representative from the United Nations Population Fund (UNFPA) described this practice as a form of violence against women.

The Ministry of Public Health sponsored a two-day seminar January 9-10, 2001 entitled "Female Health" on FGM/FGC. It was funded primarily by the U.S. MacArthur Foundation. Nearly 150 academics, health professionals, government officials, donors and clerics attended. This conference marks the first time FGM/FGC has been publicly discussed in Yemen. In his opening remarks, the Minister of Public Health described this practice as a form of violence against women and a violation of their human rights.

A plan of action to reduce the incidence of FGM/FGC in Yemen was established at the conference. Religious leaders were tasked to provide a legal opinion on FGM/FGC in consultation with doctors. Concerned ministries were asked to develop a public awareness campaign in areas most affected by this practice. The MOPH was asked to conduct a nationwide study to determine the extent of this problem. It was recommended that this subject be included in the curricula at medical schools, health institutes and literacy centers and that a law be promulgated to prohibit this practice.

LEGAL STATUS:

There is no law against FGM/FGC in Yemen. A ministerial decree effective January 9, 2001, however, prohibits the practice in both government and private health facilities.

PROTECTION:

We are unaware of any groups that would offer support or protection for a woman or girl against this practice.

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